STANDARDS FOR PRIVATE LONG-TERM CARE INSURANCE

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FIRST CONGRESS

FIRST SESSION

MAY 17, 1989

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STANDARDS FOR PRIVATE LONG-TERM CARE INSURANCE

WEDNESDAY, MAY 17, 1989

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The subcommittee met, pursuant to call, at 11:10 a.m., in room B-318, Rayburn House Office Building, Hon. Fortney Pete Stark (chairman of the subcommittee) presiding.

[The press releases announcing the hearing follow:]

FOR IMMEDIATE RELEASE
THURSDAY, FEBRUARY 23, 1989

PRESS RELEASE #5
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE FORTNEY PETE STARK (D., CALIF.), CHAIRMAN, SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES, ANNOUNCES A HEARING ON THE ESTABLISHMENT OF STANDARDS FOR PRIVATE LONG TERM CARE INSURANCE

The Honorable Fortney Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will hold a hearing on the establishment of standards for private long term care insurance. The hearing will focus on legislation to be introduced by Mr. Stark, similar to H.R. 5085 in the 100th Congress. The hearing will be held on Wednesday, March 22, 1988, beginning at 9:30 a.m., in room B-318 Rayburn House Office Building.

In announcing the hearing Chairman Stark said, "Our senior citizens must be protected from abusive and misleading advertising regarding health insurance. The existing standards have made an important contribution in MediGap -- we should do the same with long term care."

Oral testimony will be heard from invited witnesses only. However, any individual or organization may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing.

BACKGROUND

The proposed legislation establishes consumer protection standards for private long term care insurance, similar to those already developed to regulate so-called MediGap policies.

Under existing law, there are no Federal standards for the regulation of private long term care insurance. The National Association of Insurance Commissioners has developed a prototype Long Term Care Insurance Act for adoption by the States.

At present, about 70 insurance companies are selling long term care insurance and are covering approximately 500,000 individuals.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

For those who wish to file a written statement for the printed record of the hearing, six (6) copies are required and must be submitted by the close of business on Friday, April 7, 1989, to Robert J. Leonard, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Subcommittee office, 1114 Longworth House Office Building, before the hearing begins.

* * * POSTPONEMENT OF HEARING * * *

FOR IMMEDIATE RELEASE
TUESDAY, MARCH 7, 1989

PRESS RELEASE #5-REVISED
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE FORTNEY PETE STARK (D., CALIF.), CHAIRMAN,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES,
ANNOUNCES A POSTPONEMENT OF THE HEARING ON
THE ESTABLISHMENT OF STANDARDS FOR
PRIVATE LONG TERM CARE INSURANCE

The Honorable Fortney Pete Stark (D., Calif), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced a postponement of the hearing scheduled for Wednesday, March 22, 1989, on the establishment of standards for private long term care insurance (announced in press release #5, dated February 23, 1989).

A new date will be announced in a subsequent press release.

* * * * *

FOR IMMEDIATE RELEASE
TUESDAY, MAY 2, 1989

PRESS RELEASE #13
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE FORTNEY PETE STARK (D.,CALIF.), CHAIRMAN, SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES, ANNOUNCES A NEW DATE FOR THE HEARING ON STANDARDS FOR PRIVATE LONG TERM CARE INSURANCE

The Honorable Fortney Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, today announced that the Subcommittee's hearing on standards for private long term care insurance has been rescheduled for Thursday, May 18, 1989, beginning at 10:00 a.m., in room B-318 Rayburn House Office Building. The hearing will focus on H.R. 1325, a bill introduced by Chairman Stark to establish standards for private long term care insurance policies.

The hearing, originally scheduled for Thursday, March 22, 1989, was postponed. Please see press release #5, dated February 23, 1989, for additional details regarding the hearing.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Persons wishing to submit written comments for the printed record of the hearing should submit at least (6) copies of their statement by the close of business, Friday, June 2, 1989, to Robert J. Leonard, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Subcommittee office, 1114 Longworth House Office Building, before the hearing begins.

SEE FORMATTING REQUIREMENTS BELOW:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will **not** be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.
2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.
4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and public during the course of a public hearing, may be submitted in other forms.

* * * CHANGE OF DATE AND TIME * * *

FOR IMMEDIATE RELEASE
FRIDAY, MAY 12, 1989

PRESS RELEASE #13-REVISED
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE FORTNEY PETE STARK (D.,CALIF.), CHAIRMAN,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES,
ANNOUNCES A NEW DATE AND TIME FOR THE HEARING
ON STANDARDS FOR PRIVATE LONG TERM CARE INSURANCE

The Honorable Fortney Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, today announced that the Subcommittee's hearing on standards for private long term care insurance, scheduled for Thursday, May 18, 1989, has been rescheduled for Wednesday, May 17, 1989, beginning at 11:00 a.m., in room B-318 Rayburn House Office Building. The hearing will focus on H.R. 1325, a bill introduced by Chairman Stark to establish standards for private long term care insurance policies.

All other details for the hearing remain the same. (See press release #5, dated February 23, 1989, and press release #13, dated May 2, 1989.)

* * * * *

Chairman STARK. Good morning.

The Ways and Means Subcommittee on Health continues today to look at issues related to long-term care by focusing on possible Federal standards for private, long-term care insurance.

The cost of long-term care provided either at home or in a nursing home, or in a hospital, can be financially devastating for most American families. With the average cost of institutional care at a minimum of $25,000 per year, the need for public or private coverage should be evident to all of us.

Last year, this subcommittee held a series of hearings that focused on long-term care. At that time, we heard about the projected increase in the demand for these services, the high and rising cost of such services, and the limited coverage available to seniors through public or private sources.

Almost half of all nursing home expenditures are paid for directly by patients and their families. Only 1 percent is covered by private, long-term care insurance.

Recent years have witnessed rapid growth in the private, long-term care insurance market. And while it is true that these developments hold some promise, the committee is concerned about the potential for abuse in this rapidly expanding market.

Last year, Consumer Reports published its review of private long-term care policies. They found numerous problems among the private policies included in their survey.

Since last year, the National Association of Insurance Commissioners has revised its model State statute in an effort to address some of the problems identified by consumer groups.

It is an unfortunate fact that many States have not adopted the NAIC model statute. As a result, vulnerable seniors can still buy private, long-term care insurance that have prior hospitalization requirements for nursing home care, exclusions for certain mental disorders, nursing home coverage limited to skilled facilities, and without any home care benefits.

In addition, there are a number of serious problems that have not been addressed by the NAIC.

The private, long-term care industry is growing rapidly. Seniors are paying a lot of money to protect themselves from potentially devastating expenses, and too many policies are being sold that don't provide adequate coverage at a reasonable cost.

For these reasons, I have introduced H.R. 1325, a bill to establish minimum Federal standards for private long-term care insurance. Some will say the bill doesn't go far enough because it's fairly limited to the features of the amended NAIC model statute. Others will say that Federal activity is unnecessary at this time, given changes adopted by the NAIC and the uncertainties of an evolving marketplace.

I believe that these minimal standards are absolutely essential. With the steady increase in the number of seniors putting their trust in private insurance, there is an appropriate Federal role to minimize potential abuse of vulnerable senior citizens who are trying to act prudently.

Finally, I would like to point out that private long-term care is not the panacea for which we have all been searching. While private insurance may hold some promise to protect the income and

assets of the more well-to-do among elderly Americans, it is by no means a comprehensive solution to address the serious problems related to long-term care financing and service delivery of moderate and low-income Americans.

Most older Americans can't afford to pay over $1,000 a year to buy private long-term care insurance. Last year, the least expensive of the comprehensive, long-term care bills would have cost somewhere in the neighborhood of $30 billion.

With the rousing success and acclaim that has met the Gradison catastrophic health insurance bill, and the seniors enthusiastic endorsement of paying for it themselves, I see a great future for long-term care insurance that will arguably cost 5 to 10 times more than the modest expansion under the catastrophic insurance bill. So I look forward to interesting comments by our witnesses today.

Our first witness this morning will comprise a panel. Josh Wiener is a senior fellow in economics at Brookings Institution. He has been working with Dr. Alice Rivlin on a major study on long-term care and has coauthored a book "Caring for the Disabled Elderly." Dr. Wiener testified before this subcommittee last year and we're pleased to welcome him back.

He is joined on the first panel by Gail Shearer, manager of policy analysis for Consumers Union, and Gwendolyn Bedford, a member of the American Association of Retired Persons' board of directors.

I might add that Miss Shearer has just written an article which will appear in the June issue of Consumers Union dealing with MediGap policies, the need for which has been seriously reduced by the catastrophic health care bill. She raises some interesting issues in that article which I hope she will address here—that is, not necessarily the contents of the policy, but the absolutely "scruffy" way in which many people solicit leads and market these policies. It becomes apparent, as illustrated in Miss Shearer's article, that not only are the terms of the contract important, but the control of the people who are licensed to peddle these contracts may be a larger area for abuse than the contracts themselves.

Josh, if you would like to lead off. Proceed in any manner you're comfortable.

For all witnesses today, without objection, by the direction of the chairman, your statements will appear in the record in their entirety. I must apologize to the witnesses. Rarely do we have a full committee hearing and a subcommittee hearing at the same time, but that is our problem today.

And for my colleagues on the minority, the President is on the Hill today and they are meeting with him as we speak. I was asked to extend their apologies to the witnesses for their obvious absence at the beginning of this hearing.

Josh.

STATEMENT OF JOSHUA M. WIENER, PH.D., SENIOR FELLOW, BROOKINGS INSTITUTION

Mr. WIENER. Thank you, Mr. Chairman.

American society widely uses private insurance to protect against loss from potentially catastrophic events such as hospitalization, automobile accidents, home fires, theft, and early death. In-

surance against the potentially devastating costs of long-term care, however, is relatively rare. To date, only about 1.1 million long-term care insurance policies have been sold. And in 1987, private insurance covered only about 1 percent of total nursing home expenditures.

A 1988 survey conducted by HIAA found that the number of companies selling long-term care insurance has increased more than 6 times over the number in 1984, to more than 105 companies. Moreover, in a 21-month period ending December 1988, the number of persons purchasing private long-term care insurance increased almost three times. So we have a situation where private insurance is clearly expanding rapidly.

But it's also true, as you pointed out, that while private insurance is expanding, it's not likely to be a panacea. Private insurance is likely to have a limited impact because policies are too expensive for most elderly and policies have restrictions that limit the amount of financial protection they offer.

Now, why isn't there more private long-term care insurance? Any private long-term care insurance is a relatively recent phenomenon. There have been problems on both the supply side and on the demand side.

Focusing today on the supply side, insurers have worried about whether long-term care was, in fact, an insurable risk. They worried about "moral hazard"—the increased use of services that results when people have insurance; they worried about adverse selection—that is, who is going to buy policies but the people who know or think that they're going to use long-term care.

Finally there's a very important peculiarity about long-term care which is the long time between the initial purchase of a policy and its actual use. Long-term care is needed primarily by the very elderly population, those aged 85 and older. Thus, a policy bought at age 65 is not likely to be used for another 20 years; a policy bought at age 45 may not be used for another 40 years. Obviously, a lot can happen over 20 or 40 years. There can be radical changes in mortality rates, disability rates, use of services, inflation rates, and so on. All of these potential changes can radically affect the profitability of a policy.

Faced with these uncertainties and the lack of actual experience with an insured population, insurers have tried to protect themselves against financial loss by imposing restrictions and limitations on what policies covered. These first-generation policies typically had high deductibles, focused on skilled nursing care, had prior hospitalization requirements, didn't provide much in the way of home care, and they offered only a fixed indemnity benefit.

The net result of those restrictions was to substantially lessen the probability that a person who used either a nursing home or home care would actually receive insurance benefits. These first-generation policies have been severely criticized by myself, Consumers Union, and the United Seniors Health Cooperative, among others.

As time has gone on, the policies have improved, although perhaps not as much as some would like to think. While the average policy still has many of these restrictions, new policies introduced in 1988 are significantly better.

The problem for State insurance regulators is how to strike a balance between protecting consumers and nurturing a new product. Proponents of strict regulation fear that if tough regulations are not imposed, consumers will not be protected against inferior products and fraud. They recall the scandals that resulted from the failure to set minimum standards for Medicare supplemental insurance policies. Opponents of strict regulation argue that basically officials don't have enough information or experience to regulate intelligently and that flexibility is currently needed to prevent financial losses and to encourage industry participation.

As private long-term care insurance has grown, so has regulatory activity, most of it revolving around the National Association of Insurance Commissioners. Over the last 2 years, the NAIC Model Act and Regulation have been substantially strengthened.

Despite these advances, there are several areas that deserve more regulatory attention. I am happy to say that most of these I am about to list are on the NAIC agenda for action.

These areas include inflation protection; measurement of the activities of daily living, which are increasingly being used as a trigger for benefits; the whole issue of lapse rates and return of premium; adequately measuring loss ratios; regulating life insurance riders for nursing home benefits; and the basic financial status of companies.

The threshold issue before this committee is whether or not the Federal Government should regulate private long-term care insurance. On the one hand, insurance regulation has been historically almost entirely a State function. Moreover, given the newness of this product and its rapid evolution, there is a risk that Federal regulation may be too rigid to cope with inevitable changes. For example, the issue of lapse rates and measuring the activities of daily living deficiencies were barely perceived as serious issues just 2 years ago.

On the other hand, while substantial progress has been made, the current efforts do not guarantee that all policies sold in the United States are of high quality. As you noted, many States have yet to pass the NAIC model statute or adopt the model regulation.

Moreover, a good deal of the insurance market is, in fact, national in scope and it is questionable whether modifying policies to meet individual State requirements, in fact, makes sense. Moreover, the Federal Government is already deeply involved in health care for the elderly, both through the Medicare Program and through the regulation of supplemental policies through the Baucus amendment.

If the decision is made that Federal regulation is desirable, what regulatory strategy makes sense? There are at least three broad strategies. First, the Federal Government could adopt detailed and stringent regulations that all insurers would have to meet. The advantage of that approach would be to ensure that all policies will be of high quality. The disadvantage of this approach is that insurers may decide that the game is not worth the candle and they might drop out of the marketplace. Moreover, there is the possibility that Federal standards would be overly rigid and might not be able to adjust to new changes.

A second option would be to adopt a voluntary medigap like certification strategy that largely embodied the current NAIC standards, with some relatively modest modifications. The advantage of this approach is that a large portion of the market might upgrade to meet these higher standards, improving the average product. The disadvantage of this approach is that it could mislead consumers into thinking that policies with the "Government stamp of approval" were high-quality policies. This would not necessarily be the case.

In addition, as more States adopt the NAIC model regulation and statute, and as the NAIC improves its standards over time, Federal intervention may not, in fact, add a great deal.

A third option would be to adopt a voluntary medigap-like certification strategy that set stringent standards that few current policies could meet. The advantage of this approach would be that any policies that did meet the standard would truly deserve a Government stamp of approval. The standards would send a strong message to consumers and insurers on what constitutes a good policy. The disadvantage of this approach is that the standards might be set so high as to be considered irrelevant by insurers and, therefore, not be an influence on policy design.

To conclude, long-term care insurance is just beginning. Whatever the Congress decides to do now will be just the beginning. This, as with other long-term care concerns, is an issue that will not go away.

[The statement of Joshua M. Wiener follows:]

Testimony of Joshua M. Wiener, Ph.D.
Senior Fellow, Brookings Institution

American society widely uses private insurance to protect against loss from potentially catastrophic events such as hospitalization, automobile accidents, home fires, theft, and early death. Insurance against the potentially devastating costs of long-term care, however, is relatively rare. To date only, about 1.1 million long-term care insurance policies have been sold. And in 1987 private insurance covered only about 1 percent of total nursing home expenditures.

A 1988 survey conducted by the Health Insurance Association of America found that the number of companies selling long-term care insurance has increased more than 6 times over the number in 1984 to more than 105 companies. Moreover, in a 21-month period ending in December 1988, the number of persons purchasing private long-term care insurance coverage increased almost three times. Premium income exceeds $600 million annually and is increasingly rapidly.

Although use of private insurance is likely to spread substantially, it is unlikely to become the major source of long-term care financing. Using the Brookings-ICF Long-Term Care Financing Model, we estimate that, by 2018, private long-term care insurance may be affordable by 25-45 percent of the elderly, may account for 7-12 percent of total nursing home expenditures, and may reduce Medicaid expenditures and the number of Medicaid nursing home patients by 1-5 percent. Private insurance is simulated to have a limited impact because policies are too expensive for most elderly and policies have restrictions that limit the amount of financial protection they provide.

Why Isn't There More Private Long-Term Care Insurance?

Private long-term care insurance is a very recent phenomenon, available to any significant extent only in the last four years. There have been barriers to private insurance on both the demand and supply sides.

On the demand side, there have been three major barriers. First, historically, the elderly were disproportionately poor, making impractical financing mechanisms that required substantial premium payments. While few elderly are now rich and the elderly still have the highest poverty rate of any adult group, most current evidence suggests that, adjusting for a variety of factors, the elderly are now roughly as well off as the rest of the population.

Second, until recently, most people were unaware of their risk of needing long-term care services. People seemed willing to accept the possibility that they would someday get sick and visit a doctor or be admitted to a hospital, but few people were willing to admit that they faced a significant lifetime risk of becoming disabled and using expensive nursing home or home care. Third, many people were misinformed about what the Medicare program covered. Many people thought that Medicare covered long-term care. It does not. The debate over the Medicare Catastrophic Coverage Act of 1988 largely exploded the myth of Medicare long-term care coverage for the Congress, the media, and the general public.

On the supply side insurers worried about whether long-term care was, in fact, an insurable risk. They worried about "moral hazard"--the increased use of services that results when people have insurance. Most long-term care is currently provided by family members at no formal cost; only a minority of the disabled elderly receive any paid services. Thus, there is a substantial possibility of increased use of services by persons who would "medically" qualify.

In addition, insurers worried about adverse selection--the possibility that people who "know" they will use long-term care

services will disproportionately buy the insurance. Adverse selection may result in a service use beyond what is assumed in the premiums.

Finally, insurers have been concerned about the timing of premium payments and the ultimate use of benefits. Long-term care is needed principally by the very elderly, especially those age 85 and over. Thus, there is likely to be a very long time between initial purchase of the insurance policy and its eventual use. For example, a policy bought at age 65 probably will not be used for 20 years; a policy bought at age 45 probably will not be used for 40 years. Obviously, there is the possibility of radical changes in mortality rates, disability rates, use of services, inflation rates and so on. All of these factors could dramatically affect a policy's profitability.

What Are Long-Term Care Policies Like?

Faced with the uncertainties described above and lacking actual experience with an insured population, insurers tried to protect themselves against financial loss by imposing restrictions and limitations on what policies covered. Insurers typically tried to protect themselves against moral hazard by imposing high deductibles, focusing coverage on skilled nursing care, requiring prior hospitalization before nursing home care, and only covering home care that followed a nursing home stay. To protect against adverse selection, insurers usually screened for health problems, did not sell to persons over age 80, and did not provide coverage for preexisting conditions and most mental illnesses. To protect against the general uncertainty of the future, they typically offered only fixed indemnity benefits (e.g., $50 per day in a nursing home) that did not increase with inflation and insurers sometimes reserved the right to unilaterally cancel policies.

The net effect of these restrictions was to substantially lessen the probability that a person who used nursing home or home care would actually receive insurance benefits. These so-called "first generation" private long-term care insurance policies were strongly criticized by Consumers Union, the United Seniors Health Cooperative, and myself, among others.

As time has gone on, the policies have improved substantially, although not as much as some in the insurance industry would claim. While the average policy still has many of restrictions described above, new policies introduced in 1988 provide significantly better coverage. In particular, among newer policies, prior hospitalization requirements are eliminated, policies are guaranteed renewable, Alzheimer's disease is explicitly covered, all levels of nursing home care are covered, more home care is covered, and indemnity levels are at least partly indexed for inflation. It is important to note that these changes are largely in response to state regulatory requirements and market demand by consumers and not because insurers have gained much experience in paying claims. There is no inherent reason why policies cannot provide better coverage than they do now. However, these added benefits cannot be provided for free and will result in higher prices, thus reducing affordability.

State Insurance Regulation

Although insurance companies face some regulatory obstacles to developing and selling long-term care insurance, state insurance regulation is not a major impediment to growth. The problem for state insurance regulators is how to strike a balance between protecting consumers and nuturing a new product. Proponents of strict regulation fear that if tough regulations are not imposed, consumers will not be protected against inferior products and fraud. They recall the scandals that resulted from the failure to set minimum standards for Medicare supplemental insurance policies. Opponents of strict regulation argue that officials do not have enough information or experience to regulate intelligently and that flexibility is needed to prevent financial losses that may discourage the insurance industry.

As private long-term care insurance has grown, so has regulatory activity, most of it revolving around the National Association of Insurance Commissioners' (NAIC) Model Act and Regulation. Over the last two years, the Model Act and Regulation have been substantially strengthened and now require that policies be guaranteed renewable, cover Alzheimer's Disease, not require prior hospitalization before nursing home use (although states have an option of merely requiring that companies offer a no prior-hospitalization policy), provide a summary of coverage, have a pre-existing condition exclusion of not more than 6 months, have a 60 percent loss ratio, and not market as a home health care or home care benefit any benefit that has a prior institutionalization requirement.

Despite these advances, there are several additional issues that deserve more regulatory attention. These include:

- Inflation Protection. Because of the potentially very long period of time between initial purchase of a policy and its eventual use, inflation adjustment of the indemnity value of the benefit is absolutely critical to retain the benefits' purchasing power. If nursing home inflation is a little less than 6 percent a year, a $50 a day benefit purchased at age 65 will need to pay over $150 a day at age 85 to represent the same percentage of nursing home daily costs. While some policies now have a limited inflation adjustment, they are almost all grossly inadequate. The current NAIC regulations only require that the summary of benefits state whether there is any inflation adjustment and what that amount is.

- Activity of Daily Living (ADL) Measures. Some insurance policies now use inability to perform the activities of daily living (such as bathing, dressing and eating) as a trigger for benefits. While generally a positive development, policies do not describe how they will measure ADLs even though there can be a 45 percent difference in the estimated number of people in the community with serious problems in the activities of daily living depending on how they are defined and measured. Moreover, although policies specifically claim to cover people with Alzheimer's Disease, a substantial proportion of severely demented persons do not have serious ADL limitations. Indeed, in some cases, it is their very mobility and wandering behavior that makes them difficult to care for.

- Lapse Rates and Return of Premium or Vesting. If purchased at age 65, many people face paying premiums for 20 to 30 years. If purchased at younger ages, as urged by the industry, people will have to pay premiums for many more years. It is likely that many people will let their policies lapse. In addition, virtually all policies level premiums designed to build up substantial reserves in the early years for payout in the later years. For people who pay in during the early years and then decide to drop their policies, they will have "overpaid" for the protection they received. A complicating factor is that while the policies are sold on a level premium basis (that is, if all goes well, the premium will never increase), there is no guarantee that premiums will not be raised in the future. At least some actuaries have argued that the policies of some companies are underpriced and will be raised in the future, guaranteeing a high lapse rate. Possible solutions to people dropping their insurance policies is to return part of the premium or to allow the insured to "vest" in a reduced benefit. The current NAIC regulations do not regulate this issue directly, nor do they require insurance companies to disclose information about lapse rates.

- Loss Ratios. To prevent sale of contracts not worth buying because of their limited benefits, regulators have developed a general measure, the loss ratio, to evaluate an insurance policy's economic value. The loss ratio is the proportion of total premiums paid out in benefits to consumers during the year. Unfortunately, interpretation of simple loss ratios applied to long-term care

insurance is not straightforward and may be misleading. Computed loss ratios may be properly very low in the early years of long-term care policies, since premiums are usually collected several years in advance of expected benefit payments. The NAIC regulations recognize this complexity, while setting a minimum loss ratio of 60 percent. They do not, however, establish a standard methodology. While the anticipated loss ration is examined at the time of initial filings, actual experience is often not reported.

- o Life Insurance Riders. Life insurance riders for universal life or whole life insurance policies are now becoming available which pay for long-term care services with part of the death benefit. At this point, there is no consistent regulatory policy on these riders.

- o Financial Status of Companies. Long-term care insurance is a financially risky business, with the potential for losses that may be substantial and not apparent for many years into the future. Moreover, at the time when losses become apparent, it may be too late to do much about it. While most of the major insurance companies have entered the market, a substantial number of the policies are sold by relatively small, regional companies. It is unknown whether these companies could financially survive and pay benefits if their claims experience turned sour. While financial solvency is a general concern of state issuance commissioners, regulations that specifically address long-term care insurance are usually lacking.

Federal Regulation of Long-Term Care Insurance

The threshhold issue before this Committee is whether or not the federal government should regulate private long-term care insurance. On the one hand, insurance regulation has been traditionally a state function. Moreover, given the newness of this product and its rapidly evaluation, there is a risk that federal regulation will be too rigid to cope with the inevitable changes. For example, the issues of lapse rates and ADL measurement were barely perceived as serious issues two years ago.

On the other hand, while substantial progress has been made, the current efforts do not guarantee that all policies sold in the United States be of high quality. Many states have not yet passed the NAIC Model Statute or adopted the Model Regulation. While much of this appears to be a normal legislative and regulatory time lag, it is possible that some states will not adopt the Statute or Regulation. Moreover, a good deal of the insurance market is national is scope and it is questionable whether modifying policies to meet individual state requirements makes sense. Finally, the federal government is already deeply in involved in health insurance for the elderly through the Baucus Amendment, which created the voluntary Medigap certification program.

If the decision is made that federal regulation is desirable, what regulatory strategy makes sense? There are at least three broad options. First, the federal government could adopt detailed and stringent regulations that all insurers would have to meet. The advantage of this approach is that it ensures that all policies will be of high quality. The disadvantage of this approach is that insurers might decide that the compliance costs are too high and drop out of the market. An additional problem might be that if detailed requirements were specifically written into law, there might not be the flexibility to address new issues as they arose.

A second option would be to adopt a voluntary Medigap-like certification strategy that would embody the current NAIC standards with some relatively minor modifications. A substantial portion of current policies would meet this standard. The advantage of this approach is that a large portion of the market might upgrade to meet these higher standards, improving the average insurance product. The

disadvantage of this approach is that it could mislead consumers into thinking that policies with the "government stamp of approval" were high quality policies. This would not necessarily be the case. In addition, as more states adopt the NAIC Model Regulation and Statute and as the NAIC improves its standards over time, federal intervention may not add a great deal.

A third option would be to adopt a voluntary Medigap-like certification strategy that set stringent standards that few, current policies could meet. The advantage of this approach would be that any policies that did meet the standard would truly deserve a "government stamp of approval." The standards would send a strong message to consumers and insurers on what constitutes a good policy. The disadvantage of this approach is that standards may be set so high as to be considered irrelevant by insurers and, therefore, not an influence on policy design.

Summary and Conclusions

Private insurance is an exciting new initiative in long-term care financing. Long-term care has been viewed only very recently as an insurable event. Companies who write these policies are handicapped by lack of experience with how the insured and the long-term care delivery system will respond to insurance. To protect themselves, companies have developed restrictions which limit their financial risk. Unfortunately, these restrictions also limit the amount of financial protection provided to the insured and make it less likely that individuals in need of long-term care services will receive benefits from the insurance.

State insurance regulators have had to tradeoff protecting consumer interests and encouraging a financially risky new product. State regulators, encouraged by the National Association of Insurance Commissioners, are being more aggressive and standards are now substantially higher than they were just two years ago. Nonetheless, these standards are still minimal and do not guarantee that a policy will be a "good buy" from the consumer's perspective.

The Congress now faces the question of whether federal standards for long-term care insurance are a good idea. Insurance regulation is traditionally a state activity, although the Baucus Amendment established a federal role in the regulation of Medicare supplemental policies. A key question is whether the federal government or the enabling statute can be flexible enough to adapt to the changing marketplace and its evolving regulatory requirements.

If the decision is to establish federal regulations, there are at least three options. First, the federal government could set stringent and detailed regulations that all policies must meet. Second, the federal government could establish a voluntary Medigap-like certification process, setting standards that essentially endorsed the National Association of Insurance Commissioners standards with some modifications. Or, third, the federal government could establish a voluntary Medigap-like certification process, setting stringent and detailed standards.

Long-term care insurance is just developing. Whatever the Congress decides to do now will just be the beginning. This, as with other long-term care concerns, is an issue that will not go away.

Chairman STARK. Miss Shearer.

STATEMENT OF GAIL SHEARER, MANAGER OF POLICY ANALYSIS, CONSUMERS UNION

Ms. SHEARER. Mr. Chairman and members of the subcommittee, Consumers Union appreciates the opportunity to present our views on private long-term care insurance. We commend Chairman Stark for his leadership on this important issue and the subcommittee for holding this hearing.

My testimony today addresses the performance of the private long-term care insurance market and the possible impact of the National Association of Insurance Commissioners' model act and H.R. 1325.

The major points I would like to make are as follows: First, while there have been some recent encouraging developments in the private long-term care insurance market, we continue to have major concerns about how well it is meeting consumers' needs.

Second, we do not believe that the NAIC's model long-term care regulation goes far enough in protecting consumers. And finally, we have suggestions for amending Congressman Stark's proposal, so that the private long-term care insurance market will better serve consumers' needs.

In introducing H.R. 1325, Chairman Stark points out that abuses in the Medicare supplement insurance market led to Federal standards, the Baucus amendment, in 1980 and he uses the Baucus standards as a model for his long-term care proposal.

Unfortunately, the Baucus amendment has not succeeded in solving abuses in the medigap market. As you mentioned, the June issue of Consumer Reports, which is en route to subscribers this week, shows that insurance agents continue to victimize consumers and that consumers continue to face a complicated marketplace. We believe that the medigap experience argues convincingly for modifying the Baucus approach, not only to improve the medigap market, but to address problems in long-term care.

In May 1988, Consumer Reports published an indepth evaluation of 53 private long-term care insurance policies. All of the policies we reviewed had at least one major flaw, including requiring prior hospitalization before any benefit could be paid, failing to adjust for inflation, and covering only certain types of nursing home care.

In March, the Health Insurance Association of America reported on trends in long-term care insurance. Their report showed that policies in force in early 1988 had many restrictions. For example, 86 percent required prior hospitalization before paying benefits for nursing home stays, and only 21 percent had any protection against inflation. The HIAA found that policies introduced in 1988 had improved, based on an analysis of 14 such policies. Only 1 of the 14 policies introduced in 1988 required prior hospitalization, and over 70 percent increased benefits over time to account for inflation.

While we are encouraged by the trends, we continue to have several major concerns about this market. It is important to recognize that the basis of many of HIAA's conclusions is their analysis of 14 plans introduced in 1988. We should not lose sight of the fact that

old policies continue to be marketed in 1989. As the HIAA report notes, the early generation products tend to have severe restrictions.

Some of our key concerns about the long-term care insurance market are, first, the question of low value. We expect that many long-term care policies will divert around half of the premium dollars collected to pay for administrative costs, marketing, and profits. We urge this subcommittee to consider a regulatory approach—standardization—that has the potential to dramatically increase the value per premium dollar paid. Under standardization, policy benefits could not vary from standard levels set forth in low, medium, and high policies, which would range from less comprehensive to more comprehensive. The Government would establish uniform definitions for key policy terms and would restrict the variations allowed for other insurance policy provisions. Standardization has dramatically improved the performance of the medigap market in Massachusetts and holds great potential for the long-term care market.

The second problem is variation. Policy provisions continue to vary considerably, and the bottom line for consumers is confusion. We do not believe that consumers can make a rational comparison of policies when so many features vary from one policy to another. Policy standardization would simplify the market and allow consumers to comparison shop effectively.

The third problem is unfair pricing practices. Companies with guaranteed renewable policies are free to increase the so-called level premium if they increase it for everyone else in the State who has the policy. This amounts to "bait, lock in, and switch" for consumers, who are forced to make a purchase decision without knowing the cost in future years.

Fourth is the problem of agent abuses, which you referred to. Tragic examples of victimized consumers are already turning up across the country. The medigap and the long-term care markets share the same high, first year agent commission structure, which leads to strong incentives for insurance agents to try to replace policies.

Consumers have complained to State insurance departments about inappropriate denial of claims by insurance companies. One company is the subject of hundreds of complaints across the country.

Some of the things that our medigap article points out with regard to the medigap market is that lead card companies that you referred to send mailings to senior citizens making it sound like they represent either the Government or consumer groups, and they often exaggerate the limitations of Medicare so that they basically encourage the person receiving the mailing to send in their name and address. The agents then will prospect these people and try to sell them either medigap policies and often long-term care policies as well. The agents tend to pressure consumers into buying policies——

Chairman STARK. We call that the Jimmie Roosevelt approach.

Ms. SHEARER. I won't comment on that.

The abuses in the medigap market include overloading. Many complaints have been filed in the long-term care market. One of

the problems a consumer complained about is that the agent had pressured the person into buying a policy and then, when the consumer was exercising his right to return the policy for a refund within 30 days, the company did not send the refund for something close to a year.

We find that many of the same companies are involved in both the medigap market and the long-term care market, and many of the same agents are involved as well. So we think that a lot of the conclusions from the medigap market will apply to the long-term care market.

A fifth problem is inflation. Inflation can severely erode the value of a long-term care insurance policy. Inflation adjustments, when they exist, are often inadequate, since they fail to protect fully against reduced purchasing power in the long term.

A sixth problem area is refunds. Policyholders who drop their policy, perhaps to buy a better policy, are out of luck. We believe that policies should provide such policyholders with a refund equivalent to cash value in whole life insurance, since early year premiums are used to subsidize later year risks.

The seventh problem area is escaping State regulation. Some companies now escape regulation by registering a group contract in one State and then selling policies, and defrauding consumers, in several other States. The local State is unable to reach the violation. We urge Congress to address this problem, possibly through increased powers for the Federal Trade Commission.

An eighth problem area is insolvency. Widespread insolvencies could leave consumers without the protection they are counting on. State regulators and Congress need to keep a vigilant eye on pricing practices and State guarantee systems that are designed to protect consumers in the event of insurer insolvency.

Finally, the owners of "old" policies. About 1 million consumers of early-generation policies have relatively poor coverage and do not benefit from recent improvements in new policies on the market. Owners of early-generation policies should be given the opportunity to upgrade their coverage.

The NAIC model regulation on long-term care insurance, as recently amended, will improve market performance somewhat. While State regulators recognize the problems I have identified in my testimony, the NAIC model does not presently address them.

Chairman Stark's bill, H.R. 1325, builds on the NAIC model. We urge you to amend it with additional consumer protection measures to address our concerns.

Our specific suggestions are outlined in our written statement. In brief, we recommend that the bill be amended to standardize the market; eliminate high, first-year commissions for agents; require real protection against inflation; require establishment of State counseling programs; prohibit underpricing of policies; require refunds for consumers who drop their coverage; establish a system to protect against abuses that escape effective State regulation because of their interstate nature; protect consumers against insurer

insolvency; and require improved protection to consumers of early-generation policies.

Mr. Chairman, thank you for the opportunity to present our views.

[The statement and attachment of Gail Shearer follow:]

Statement of Gail Shearer, Manager, Policy Analysis, Consumers Union

Mr. Chairman and members of the Subcommittee, Consumers Union* appreciates the opportunity to present our views on private long-term care insurance. We commend Chairman Stark for his leadership on this important issue and the Subcommittee for holding this hearing.

My testimony today addresses the performance of the private long-term care insurance market and the possible impact of the National Association of Insurance Commissioners' (NAIC) model act and H.R. 1325. The major points I would like to make are as follows: First, while there have been some recent encouraging developments in the private long-term care insurance market, we continue to have major concerns about how well it is meeting consumers' needs. Second, we do not believe that the NAIC's model long-term care regulation goes far enough in protecting consumers. Finally, we have suggestions for amending Congressman Stark's proposal, H.R. 1325, so that the private long-term care insurance market will better serve consumers' needs.

In introducing H.R. 1325, Chairman Stark points out that abuses in the Medicare supplement insurance market led to federal standards (the Baucus Amendment) in 1980, and he uses the Baucus standards as a model for his long-term care proposal. Unfortunately, the Baucus amendment has not succeeded in solving abuses in the medigap market. The June issue of Consumer Reports, which is en route to subscribers this week, shows that insurance agents continue to victimize consumers and that consumers continue to face a complicated marketplace. We believe that the medigap experience argues convincingly for modifying the Baucus approach not only to improve the medigap market, but to address problems in long-term care.

We note that we prefer either a social insurance long-term care program or government-administered optional long-term care insurance. Our testimony today is limited to the issue of how to improve the performance of the private market. We want you to know, though, that we would very much like to work with this Subcommittee on legislation that would address the larger long-term care problem: extending protection against the devastating costs of long-term care to low and moderate income Americans, to people who are unable to qualify for private policies because of health conditions, and to people too young to buy a policy but nevertheless at risk of needing long-term care services.

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PERFORMANCE OF THE PRIVATE LONG-TERM CARE INSURANCE MARKET

In May 1988, Consumer Reports published an in-depth evaluation of 53 private long-term care insurance policies. (A copy of the article is attached to my testimony). All of the policies we reviewed had at least one major flaw, including requiring prior hospitalization before any benefit could be provided, failing to adjust for inflation, and covering only certain types of nursing home care.

In March, the Health Insurance Association of America (HIAA) reported on trends in long-term care insurance. [Susan Van Gelder and Diane Johnson, "Long-Term Care Insurance: Market Trends, Health Insurance Association of America, March 1989] The report shows that policies in force in early 1988 had many restrictions. For example, 86 percent required prior hospitalization before paying benefits for nursing home stays, and only 21 percent had any protection against inflation. The HIAA found that policies introduced in 1988 had improved, based on an analysis of 14 such policies. Only one of the 14 policies introduced in 1988 required prior hospitalization, and over 70 percent increased benefits over time to account for inflation.

While we are encouraged by the trends, we continue to have several major concerns about this market. It is important to recognize that the basis of many of HIAA's conclusions is their analysis of 14 plans introduced in 1988. We should not lose sight of the fact that "old" policies continue to be marketed in 1989. As the HIAA report notes, the early-generation products tend to have severe restrictions.

Some of our key concerns about the long-term care insurance market are as follows:

1. Low value. Considering the NAIC model regulation's target loss ratio of 60 percent, combined with the medigap market's failure to meet its target loss ratio, we predict that many long-term care policies will divert around half of the premium dollars collected to pay for administrative costs, marketing and profits. We urge this Subcommittee to consider a regulatory approach -- standardization -- that has the potential to dramatically increase the value per premium dollar paid. Under standardization, policy benefits could not vary from standard levels set forth in "low," "medium," and "high" policies, which would range from less comprehensive to more comprehensive. In addition, regulators should exclude the poorest performers from the market.

2. Variation. In Consumers Union's recent report "Long-Term Care: Analysis of Public Policy Options," [Consumers Union, January 1989, pp. 33-35] we found that policy provisions continue to vary considerably, and the bottom line for consumers is confusion. We do not believe that consumers can make a rational comparison of policies when so many features vary from one policy to another.

3. Unfair Pricing Practices. Most long-term care policies are "level-premium" policies. This does not mean that premiums will remain level. It means that premiums will not automatically increase each year as the policyholder ages. Companies with "guaranteed renewable" policies are free to increase the so-called level premium if it also increases it for everyone else in the state who has the same policy. This leads to strange incentives for insurance companies. Companies have a strong incentive to underprice the policy initially in order to attract customers, and then raise premiums in later years, once

consumers are locked in. Consumers are forced to make a purchase decision without knowing the cost in future years. This is worse than "bait and switch." It amounts to "bait, lock-in, and switch." In contrast, with life insurance, at least future premium increases are disclosed prior to sale. "Noncancellable" policies are not allowed to increase premiums. The recent HIAA survey did not indicate that any of the new policies are noncancellable.

4. Agent abuses. In the medigap market, there is a long history of agent abuses with catchy names such as "twisting," "rolling over," "overloading." Unfortunately, the same types of abuses are turning up in the long-term care market. There are already tragic examples of "post-claims underwriting." This occurs when agents deliberately fail to note down health problems that the applicant identifies when applying for a policy. When a claim is filed, the company discovers the pre-existing condition and denies benefits. One company has been the subject of hundreds of complaints across the country. The same company settled a civil case in Arizona for a large amount of money; in this instance a woman filed a case on behalf of both her mother and her father. Each had purchased a policy and had later claims denied. Agents and companies are slipping between the regulatory reach of state insurance departments. Attached to my testimony is a list of sample complaints from insurance department files about abuses in this market.

Estimates vary, but we know that at least one-fifth of the elderly have duplicative medigap policies. We are concerned that consumers will be subject to pressure to "overload" on long-term care policies as well. The medigap and long-term care markets share the same high first-year agent commission structure, which leads to strong incentives for insurance agents to try to replace policies.

5. Inflation. We are concerned about inadequate protection against inflation and about the potential for misunderstanding inflation adjustments in policies. Most health insurance has service benefits. In other words consumers are reimbursed a percent of charges, e.g., 80 percent, of costs. In contrast, most long-term care policies offer indemnity benefits, e.g., $50 per day. We do not believe that policies with modest (but limited) benefit increases protect adequately against inflation. For example, a policy with a 5 percent per year increase for 10 years (less if the policyholder reaches a certain age) leaves a 20-year policyholder with inadequate protection against high inflation levels. A 7 percent per year inflation rate in policy years 10 through 20 would cut the policy benefits in "real" terms in half. We believe that inflation adjustments should adequately protect consumers against inflation.

6. Refunds. Policyholders who drop their policy, perhaps to buy a better policy, are out of luck. We believe that policies should provide policyholders with a refund (equivalent to cash value in whole life insurance), since early year premiums are used to subsidize later year risks.

7. Escaping State Regulation. Some companies now escape regulation by registering a group contract in one state and then selling policies (and defrauding consumers) in several other states. The local state is unable to reach the violation. We urge Congress to address this problem, possibly through increased powers for the Federal Trade Commission.

8. Insolvency. We are concerned about the possibility of widespread insurer insolvency in the future, especially in light of the incentives insurers have (initially) to underprice their product. Even if underpricing is unintentional, insolvencies could leave policyholders without the protection they counted on. State regulators and Congress need to keep a vigilant eye on pricing practices and state insurance systems that are designed to protect consumers in the event of insurer insolvency. The systems may be inadequate to cope with widespread insolvencies.

9. Owners of "Old" Policies. The HIAA estimates that 815,000 people had bought policies before December 1987, and that 1,100,000 had bought policies by December 1988. Will owners of "early generation" policies be given the opportunity to upgrade their coverage without having to pay higher rates based on their present age (accepting, of course, higher premiums for increased benefits)?

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS' (NAIC) MODEL REGULATION AND H.R. 1325

The NAIC model regulation on long-term care insurance, as recently amended, will improve market performance somewhat. It establishes a minimum standard for policy coverage. It eliminates prior hospitalization requirements and establishes a 30-day period during which consumers can review the policy and get a premium refund if not satisfied. It sets a maximum time period of six months preceding the date of coverage for defining pre-existing conditions. It does have several serious weaknesses, however. I should point out that the state regulators recognize that many problems exist and are considering how to respond to them. Some of the key problems with the model are that it:

-- allows administrative and marketing costs and profits to consume close to 50 percent of premium dollars;

-- fails to protect against inflation;

-- fails to simplify the choices through standardization of policy provisions;

-- does nothing to prevent companies from underpricing their policies in early years, and then drastically raising rates on so-called "level premium" policies.

-- does not require companies to pay the life insurance equivalent of "cash value" to policyholders who cancel their policy.

-- does nothing to alter the commission structure that rewards agents for replacing policies.

-- does not address the need to intensify monitoring of insurer solvency.

Chairman Stark's bill, H.R. 1325, builds on the NAIC model. We support the provision to prohibit the conditioning of non-institutional benefits on the prior receipt of institutional care, without exceptions. We acknowledge that consumers who purchase a long-term care policy would benefit from raising the floor of policy coverage. But we urge you to amend H.R. 1325 with additional consumer protection measures to address our concerns. Specifically, we recommend the following changes to H.R. 1325:

1. Standardization. The long-term care market should be standardized, with three or four standard policies, ranging from less comprehensive to more comprehensive. Under standardization, the government would establish uniform definitions for key policy terms (e.g., terms such as skilled nursing facility and custodial care facility) and restrict the variations allowed for other insurance policy provisions (such as length of waiting period or inclusion of home care). Policy standardization should be distinguished from "minimum standard" types of regulation. Under minimum standards, insurers are free to offer benefits greater than the minimum standard. Under standardization, no such variation is allowed, though a controlled amount of innovation could be allowed through centrally regulated "rider" program. Insurers could be allowed to test new types of coverage within guidelines that would prevent proliferation of unnecessary (or even frivolous) variation.

Standardization has dramatically improved the performance of the medigap market in Massachusetts and holds great potential for the long-term care market. In 1986, the General Accounting Office reported that the most popular medigap policy in Massachusetts had a loss ratio of 98 percent, in a market where commercial policies averaged 60 percent and Blue Cross/Blue Shield policies overall averaged 81 percent. With standardization of the long-term care market, not only would consumers be able to comparison-shop in a rational manner, but loss ratios should improve dramatically since marketing and administrative costs should be reduced.

2. Pricing. Companies should be prohibited from deliberately underpricing their product. One option would be to limit premium increases to the cost index of covered services. (Benefits would have to be indexed as well). This would shift the cost of actuarial mistakes from consumers' shoulders to the companies' balance sheets. (It also could increase the need for monitoring company solvency.) Another option is for state regulators to monitor pricing practices vigilantly and penalize or ban from the market policies that have underpriced their coverage. This option would require more enforcement resources at the state level.

3. Agent abuses. Agent abuses should be curbed by eliminating the high first year commission and by increased enforcement efforts (and coordination between states) to weed out the bad agents.

4. Inflation. Ideally, all long-term care policies should protect policyholders against inflation. One option is to build in inflation protection by requiring that benefits be service benefits, not indemnity benefits. Another option is to require that all policies offer an inflation rider, requiring a uniform index for calculating the inflation adjustment. A third (less protective) option is to require that all policies offer an inflation rider, with full disclosure of the index used to determine the extent of benefit increases. This is the approach recently adopted in Massachusetts. Insurers could also be required to disclose what a day in a nursing home is expected to cost when the purchaser reaches age 80 or 85.

5. Refunds. Consumers who have paid in premiums for several years but then drop their policy should be eligible for a refund, just as whole life insurance policyholders receive a "cash value" when they discontinue a whole life policy.

6. Closing Regulatory Gaps. The bill should include a mechanism for policing fraudulent practices that cross state lines. Ideally, the legislation would require Federal Trade Commission monitoring of practices that can not be reached by the local state. At a minimum, the bill should call for a study of the abuses that escape regulator scrutiny because of limited jurisdiction of state insurance departments.

7. Insolvency. State regulators should be required to examine the adequacy of the existing guaranty fund system for adequately protecting consumers in the event of insurer insolvency.

8. Protecting Owners of "Old" Policies. About one million consumers purchased early-generation products. The bill should require that companies who offer new and improved policies give these consumers the opportunity to upgrade their coverage, without having to requalify, be subject to new waiting periods, or pay higher rates based on their present age (accepting higher premiums for increased benefits).

9. Education/counseling. H.R. 1325 requires that the Secretary of DHHS provide each Medicare beneficiary with information "to aid in evaluating the value of long-term care policies and the relationship of any policy to Medicare benefits." We recommend that the bill be expanded to also include a requirement that states establish counseling programs, similar to the Health Insurance Counseling and Advocacy Program (HICAP) in California, and Senior Health Insurance Benefits Advisers (SHIBA) programs several other states have. The purpose of the counseling program would be to help senior citizens review their Medicare coverage, Medicare supplement insurance policy, and long-term care insurance needs. HICAP has achieved $1,600,000 in savings for seniors, of which $403,000 was from cancellation of duplicative or unnecessary insurance policies, since it was established in 1983.

We have additional concerns that H.R. 1325's certification proposal could do more harm than good. "Twisting" (convincing a client to switch policies, thereby increasing exclusions for pre-existing conditions), and "loading up" (selling multiple overlapping policies) are two types of abuses prevalent in the medigap market. A U.S. government "seal of approval" would actually help agents convince the elderly to change long-term care policies, and hence be subject to new waiting periods, pre-existing condition restrictions, and higher premiums. Certification could also lead agents to convince consumers to buy more policies than would be desirable.

Thank you for the opportunity to present our views. We would welcome the opportunity to work with you to improve the long-term care insurance market for consumers.

ATTACHMENT

EXAMPLES OF COMPLAINTS FROM STATE INSURANCE DEPARTMENT FILES

1. Claim denied: nursing home confinement was not necessary (despite attending physician letters specifying that ongoing treatment necessary for dorsal spinal fractures).

2. Claim denied: nursing home care received was not "skilled" care as defined in certificate, despite doctor's contention that condition required skilled medical care.

3. Delay of 4 months between date paid for new policy and date that consumer received copy of insurance policy.

4. Company refused to refund premium ($1066) for nursing home policy after consumer had exercised right to return policy within 10 days from date of receipt if not fully satisfied. (Agent had pressured consumer to purchase policy.)

5. Company denied claim because illness started during the first 30 days the policy was in force, and the small print in the policy restricts coverage during this period.

6. Company denied claim saying that mental disorders (senile dementia) are excluded from coverage, though doctor claimed patient was admitted to nursing home for treatment of pneumonia.

7. Company denied claim saying that treatment in nursing home was not for same reason claimant was hospitalized (even though Medicare had the same requirement, and had approved the nursing home stay). (North Dakota Insurance Commission wrote in letter "Your denial stems from the selection of one of four reasons for Mr. Miller's admittance, while ignoring the other three reasons which would support his claim.")

Who can afford a nursing home?

Who can afford a nursing home?

This year, 2.3 million of the nation's elderly will be living in a nursing home. Three decades from now that number will nearly double. A year in a nursing home now costs on average $22,000 or more. By the year 2018, it will cost about $55,000 if inflation stays at recent moderate rates.

Who will pay the bill?

Medicaid, the Federal program that finances health services for the poor, paid half of the $38-billion that went into nursing-home care in 1986. Most people aren't poor when they enter a nursing home, but they become poor soon after.

The other half of the $38-billion came out of the pockets of nursing-home residents or of their children, who often find themselves squeezed between the financial needs of their own family and the burden of caring for aged parents.

Contrary to popular belief, Medicare, the Federal program that provides health care for the aged, pays only a tiny fraction of the cost of nursing-home care.

The Reagan Administration believes that the Federal government has no role to play in providing long-term care unless you're poor. The nonpoor, it tells us, should look to private insurance companies for protection against the potentially devastating financial consequences of a prolonged stay in a nursing home. As a result, long-term-care insurance policies, unknown until a few years ago, have proliferated. Currently, some 70 companies, ranging from familiar giants like Aetna and John Hancock to lesser-known firms like Reserve Life and Pilgrim Life, have entered the field. For this report, we analyzed 53 of their policies.

We'd like to report that private insurance policies can meet the increasingly urgent need for long-term-care coverage at a moderate cost. But many of the insurance policies we looked at were very expensive, severely limited in their coverage, or both. People who buy them at age 65 may have to pay as much as $100 a month for adequate coverage. People who try to shop for them will run into a crazy quilt of charges, waivers, and limitations that confuses even the insurance agents who sell the policies.

Illustrations by Petko

Charts by Corinne Arbuckle Hefner

Defining the policy

Simply stated, long-term-care insurance pays a set amount each day for a specified period of time that a policyholder stays in what's called a "covered nursing facility." Unlike other kinds of health insurance, these policies usually don't reimburse the policyholder for fees actually charged. The fixed benefit is one major drawback of nearly all such policies. Should you buy a policy today and enter a nursing home 10 years from now, you may find that the benefit pays a much smaller part of the actual cost than you thought it would at the time you bought the policy. Only a few policies offer a rider that adjusts the benefit annually for inflation.

Furthermore, you'll find huge differences in dollar benefits, in definitions of covered nursing facilities, in the length of time benefits are paid, in limitations on coverage, and in eligibility for benefits. Those differences are spelled out in the Ratings on page 304.

Type of facility covered

There are three types of long-term-care facility: skilled, intermediate, and custodial. A policy may or may not cover care in all three types, and different policies may define the three types of facility differently. In general, the definitions are the following:

Skilled nursing. Such care must be prescribed by a doctor, given by a skilled nurse, and be available for 24 hours a day. These facilities are licensed by the state, and daily medical records are kept on each patient.

Intermediate. In such facilities, care may require the skills of a nurse, but the level of care is somewhat less than that given in a skilled-care facility. For example, a nurse may be on hand only to give patients injections or to change their bandages. The facility may be licensed and may provide post-hospital and rehabilitative nursing care.

Custodial. Care here means helping a person with such routine activities as getting out of bed, walking, eating, and bathing. It may be given by people without professional skills or training, but some insurance policies may require that the facility be licensed.

The best policies pay benefits for all three kinds of care in all three types of facility. Buy less than the best, and you may discover that your insurance doesn't cover the type of care you require.

Note that policies can imply coverage where none exists. For example, a poucy might provide coverage for all three *types* of care, but require that the care be given in only *one* type of facility, such as a nursing home that provides skilled care.

Custodial care is sometimes covered only if it is provided in a skilled- or intermediate-nursing facility. Some policies pay no benefits for custodial care, nu matter where it's given. That's a major deficiency. Very few people need skilled care for long periods; much of the care in nursing homes is of the intermediate or custodial variety. Stroke victims, in particular, often require a long period of custodial care while recovering.

Qualifying for benefits

Most policies require beneficiaries to be hospitalized for at least three days before they enter a nursing home. And usually the nursing home must continue to provide care for the illness or condition that put the individual in the hospital.

Furthermore, the person must check into the nursing home within a certain period after checking out of the hospital. That period is usually 30 days, but it can be as short as 14 days or as long as 90 days. These rules can limit the usefulness of the insurance. Such debilitating conditions as arthritis and Alzheimer's disease usually do not require hospitalization. Only about 40 percent of all nursing-home patients check in after a hospital stay.

A few policies do not demand a hospital stay before paying benefits for long-term care. But the companies that issue them, including Blue Cross/Blue Shield and Metropolitan Life, do retain the power to decide who is eligible for benefits. Some companies, including MidAmerica and Continental Casualty, offer buyers a choice of policies with and without "prior-hospitalization" rules. Of course, the ones without these rules generally cost more.

We found nine policies free of either the prior-hospitalization rule or the company's veto of a policyholder's eligibility for nursing-home coverage.

Other restrictions may stand in the way of custodial care, which is potentially the longest-lasting and hence the most costly type of care. John Hancock's individual policy, for example, pays for care in a custodial facility only after 14 continuous days of skilled-nursing care. Aetna pays for a policyholder's first stay in a custodial facility only after a stay in either a skilled or an intermediate-care facility.

What's not covered?

No policy pays benefits for stays in rest homes or old-age homes. Nor do they pay for stays in mental hospitals or alcohol and drug rehabilitation centers. Most significantly, long-term-care policies tend to limit benefits for existing health problems and for Alzheimer's disease, the very reasons people might seek coverage in the first place.

Most companies limit coverage for "preexisting conditions"—those illnesses or diseases a buyer has when the policy is issued. The preexisting-conditions clause acts as a gatekeeper, turning away those who want to buy the coverage because they know they need it. If a company does not have a preexisting-conditions clause, it usually retains the power to decide who's eligible for benefits.

Most policies define a preexisting condition as any health problem experienced by the policyholder in the six months prior to buying the policy. But a number of policies count back one to three years.

If the insurance company sells a policy to a person with such a preexisting condition, it sets a waiting period before coverage for that condition can begin. These periods range from six months to two years. So if a heart condition lands someone in a nursing home three months after the policy was issued, the company won't start paying benefits immediately.

Virtually all the policies exclude care for mental and nervous disorders. Does that include Alzheimer's disease, a debilitating condition that's diagnosed in about half of all nursing-home patients?

Although Alzheimer's is not specifically excluded, about half the policies we looked at said something like "we won't pay for confinements due to mental illnesses except those with demonstrable organic disease." Alzheimer's disease is a degenerative brain disease with symptoms that mimic those of mental illness. It's considered an organic disease and therefore would seem to be covered. But is it a *demonstrable* organic disease? Only a biopsy or an autopsy can confirm a diagnosis of Alzheimer's disease.

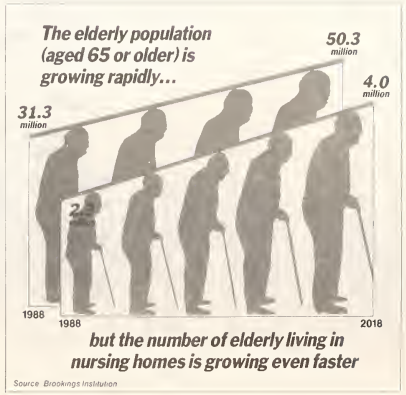
In our opinion, the vague policy language gives insurance companies too great an opportunity to contest a claim on the grounds that Alzheimer's disease has not been demonstrated. A company suddenly flooded with claims from policyholders with Alzheimer's disease might rely on that language as a basis for denying nursing-home coverage.

Other policies clearly state that Alzheimer's disease is covered. But here, again, there's a catch. Many of these policies also impose the prior-hospitalization rule. Most Alzheimer's patients, as we've noted, do not require hospitalization before they enter a nursing home.

When we asked an Aetna salesman about this, he replied: "To tell you the honest-to-goodness truth, if a doctor didn't find some way to get you into a hospital, then you're in trouble."

How large a benefit?

Daily benefits range from $25 to $100. Some policies offer a choice of benefit amounts. Obviously, it makes sense to pick a policy with benefits that closely match local nursing-home costs. A policy



paying $40 a day when the local nursing home costs $140 isn't much help. A call to two or three homes will help to establish a reasonable range of daily charges. Nationally, the average cost of a nursing home is $60 a day.

Sometimes insurance companies pay smaller benefits for custodial care than for skilled and intermediate care. The Gerber Life policy, for instance, pays a $75 benefit for skilled-nursing care, a $50 benefit for intermediate care, but only $25 if a policyholder needs custodial care.

When do benefits begin?

Policyholders can often decide when they want their coverage to start—as soon as they enter a nursing home, 20 days later, or even 100 days later. The longer this "waiting period" (sometimes called an elimination period), the cheaper the policy.

How long do benefits last?

The best policies pay benefits for an unlimited number of days for each stay in a nursing home and an unlimited number of days for all nursing-home stays. Those stays in a nursing home are sometimes called "periods of confinement" or "benefit periods."

Other policies pay benefits for a specific number of days, ranging from 730 (two years) to 3650 (10 years) for one stay, and from 730 days (two years) to 2555 (7 years) for all nursing-home stays. A few policies don't limit the number of days they'll pay benefits. They set dollar maximums instead.

In order to receive benefits for a repeat stay in a nursing home, the policyholder must usually have been out of a nursing home for at least 180 days. And when he or she returns, the waiting period starts all over again, so coverage doesn't begin immediately. Waiting periods for preexisting conditions don't begin again, however.

Sometimes a policy will have a shorter benefit period for intermediate or custodial care than for skilled-nursing care. This could be a severe limitation, since nursing-home patients require skilled care less often than intermediate or custodial care. Nearly 40 percent of all nursing-home patients stay longer than six months. Chances are good that those longer-staying patients needed intermediate or custodial care, not skilled care.

Are policies renewable?

Many policies are "guaranteed renewable," a desirable feature that insurance companies like to highlight in their sales literature. The company must renew coverage each time the policyholder pays the premium.

Beware of policies that are only "conditionally renewable." The insurer can cancel the policy provided it also cancels all other similar policies in a state. That could happen if an insurance company discovers it is losing money on this relatively new type of coverage.

A number of policies are written for groups such as the American Association of Retired Persons (AARP), or even for a fictitious group set up by the insurance company for marketing and regulatory purposes. The group holds the master contract and issues certificates to individual policyholders. The master contract for the group can be canceled, but policyholders are often able to continue the same coverage on their own.

What's in a good policy?

Features	Recommended	Your policy
Daily nursing-home benefit	$80.00	$_____
Waiting period	20 days	_____
Maximum benefit period for one stay	4 years	_____
Maximum benefit period for all stays	Unlimited	_____
Does it pay full benefits in:		
Skilled-nursing facility?	Yes	_____
Intermediate facility?	Yes	_____
Custodial facility?	Yes	_____
(If not, what does it pay?)		
If it has a prior-hospitalization rule, does coverage begin within 30 days after a hospital stay of at least 3 days?	Yes	_____
Does it pay home-care benefits?	Yes	_____
Does it pay these without requiring nursing-home care, or a hospital stay?	Yes	_____
Does it have waiver of premium?	Yes	_____
Is it guaranteed renewable for life?	Yes	_____
Is Alzheimer's disease covered by specific policy language?	Yes	_____
Does the premium stay level for life?	Yes	_____
What is the Best's rating of the company?	A or A+	_____
No premium is recommended; premiums vary with the age of the policyholder:	—	$_____

What else to look for?

Here are other features we looked for in a policy:

Home care. More than half the policies in our study paid benefits for care at home. These benefits are usually offered as part of the basic policy coverage, but sometimes they are offered as a separate policy or as a rider at an additional premium. Home care typically covers convalescent care, homemaker or companion services, and occasionally even skilled-nursing care. A few policies define home care broadly enough to include care in hospices and adult day-care centers.

Typically, the home-care benefit is one half the daily benefit paid for skilled nursing or intermediate care, but that's where the similarity among policies ends. There's wide variation in eligibility for home-care benefits and in when those benefits begin and end.

Policies that require previous nursing home or hospital confinement would usually pay for home care only if it starts within 14 days after leaving the nursing home or hospital. Policies that do not have such a requirement would generally start paying as soon as the regular waiting period has ended.

Continued on page 6

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Pitching the policies

It has never been easy to understand insurance policies. It's even tougher when the agents selling them don't understand what they're selling. And when the policy sold is brand-new, it takes a miracle to avoid misunderstanding, duplication of coverage, or even inadequate coverage.

A CONSUMER REPORTS reporter listened to sales pitches given by six insurance agents in New York and Virginia. Two agents represented Aetna; the others represented Union Bankers, Bankers Life and Casualty, Gerber Life, and Mutual of Omaha. Our reporter witnessed no miracles.

She found confusing presentations from agents who were either ignorant of the provisions in their policies or who deliberately misstated them. An Aetna agent in Virginia admitted, "I've never had to explain this to someone." Some agents were remarkably low key, acting as if they didn't want to sell the policy.

Alzheimer's confusion

About half of all nursing-home patients suffer from Alzheimer's and related diseases, so shoppers would want to know whether a policy provided coverage for such illnesses. They wouldn't have found out listening to these agents or reading their sales brochures. The agents' confusion may well reflect their company's indecision over whether to provide such coverage.

The Aetna agent in Virginia allowed that "it was questionable" whether his policy covered the disease, but said the company was "still looking at it." He added, "It's a mental disease, and they're not sure."

No wonder he was confused. The sales brochure sent by Aetna said Alzheimer's was covered, but the actual language in the policy was less specific. It said that the policy did not cover confinements for mental disease or disorders without demonstrable organic disease. As we point out on page 3, that language may or may not mean the disease is covered.

The Union Bankers agent said Alzheimer's was covered, but the brochure he left noted that the policy didn't cover nursing-home stays for "mental illness or nervous disorders." Did that mean Alzheimer's is covered? Our reporter could only guess.

What's covered?

Coverage is the guts of a long-term-care policy, but agents were of no help defining the coverage or discussing the policy limitations. Here's how the Aetna agent in New York handled these questions:

What about intermediate-care coverage? The agent fumbled for his sales brochure and replied: "They define it here somewhere." What about skilled nursing care? "On this plan, you don't have to worry about the definition," he assured us.

As for limitations on coverage, he said there were none. "Once you have this policy, you're covered for everything." Everything? The policy specifically says it does not provide benefits for six months if a nursing-home stay results from a preexisting condition.

A competitor also had trouble explaining coverage. The agent from Bankers Life and Casualty said that intermediate care was the same thing as "convalescent care" and that skilled care meant that "they do a little more medical than the others."

When asked whether any prior hospitalization is required before skilled-nursing benefits could be paid, the agent for Mutual of Omaha said: "I don't think so. I've never seen where you have to be hospitalized first." He didn't look very far. That's just what his company's sales brochure said.

What Medicare pays

Many people think that Medicare covers nursing-home stays (see box page 14). Actually, it pays for skilled nursing-home care in Medicare-approved facilities for only 20 days and then all but $67.50 per day for the next 80 days. After 100 days, Medicare pays nothing.

Here's what the agents said:

The Gerber Life salesman said that 70 percent of all applicants for Medicare benefits were turned down "because Medicare doesn't have funds for skilled care." But when Medicare does accept an individual, he said, "after 100 days, they wash their hands of you."

The Bankers Life and Casualty agent said that Medicare paid for 100 percent of home health-care costs. "It's a wonderful benefit," he said, declaring that Medicare pays "for girls to come in" and "help do your hair."

The agent had let his imagination run away with him. Medicare's home-care benefit is very limited, and it certainly doesn't pay for beautician services. It pays only for part-time, intermittent skilled care and for physical or speech therapy. The provider must participate in Medicare.

What about rate hikes?

It wasn't always easy to get a straight answer about whether premiums could go up or policies could be renewed.

The Bankers Life and Casualty agent incorrectly said the premiums would never increase, wrongly labeling this policy feature as "guaranteed renewable." The policy and the sales brochure say that the company can raise premiums if it raises them for all policies like the one the agent was selling.

The Aetna agent in Virginia also assured our reporter that the premiums would not increase. "Once these premiums are set, you'll be paying them forever." He even double-checked his sales manual. "No, they shouldn't go up," he repeated. The sales literature he gave to our reporter didn't say one way or the other, but Aetna's policy is similar to the one from Bankers Life and Casualty. Both companies can raise rates for everyone who owns the same policy in the state.

The Mutual of Omaha salesman was thoroughly confused. His policy is not guaranteed renewable, but he replied, "It is and it isn't. If the state does not permit the company to renew, then we have to pull the policy." While that statement is true enough, it has nothing to do with the renewability feature of his policy.

Mutual of Omaha's sales brochure revealed that the company could refuse to renew a policy, if it refuses to renew them for all those who own that particular policy in the same geographic area of the policyholder's state.

Which one is best?

Naturally, each agent declared his policy the best. The feature they all cited as evidence was the length of time benefits would be paid—unquestionably important, but not necessarily the only measure of superiority.

The Gerber salesman touted his policy as the best because he said it paid benefits for "eight continuous years." And he knocked the American Progressive policy. But as you can see from the Ratings, the Gerber policy was hardly the best, ranking near the bottom. The American Progressive policy ranked close to the top.

What's best is a combination of features. To help you figure out which policy is best, ask for answers to all the questions listed in the box on page 4.

If you get answers that are vague or that contradict the sales literature, ask for a specimen policy. The policy will tell you exactly what's covered and what's not, setting out all the limitations you need to know about.

An agent might be reluctant to give you a specimen policy, however. When our reporter asked the Mutual of Omaha salesman for one, he refused to supply it. If that happens, write to the company. If a company doesn't give you what you need, go to one that does.

Policies usually pay home-care benefits until the regular benefit period maximum has run out. But we found policies that paid home-care benefits for other periods: 30 days, 90 days, one year, two years, or even three years.

Inflation adjustments. The greatest danger facing policyholders is the lack of inflation protection. The $40, $75, or even $100 daily benefit paid by policies today may be woefully inadequate if you need nursing-home care 5 or 10 years from now.

Only one company, Great Republic, sells a policy with built-in inflation protection. The benefit automatically increases by 5 percent each year for as long as a policyholder hangs on to the policy.

Other companies allow policyholders to buy a rider that automatically raises benefits by some amount each year, usually 5 percent. These automatic increases usually stop after 10 years. The riders generally add between 15 and 40 percent to the premium, depending on the coverage.

A few policies pay benefits based on the actual nursing-home charges. If these charges go up, then the benefits will rise as well.

Waiver of premium. Many insurers relieve policyholders of paying further premiums once they've been in a nursing home for a period of time, usually 90 days. This feature is often part of the basic policy, but occasionally policyholders will have to pay extra for it.

Assistance in finding care. A few sellers employ care coordinators who help people find facilities that are covered by their policies. Other companies have toll-free telephone numbers that policyholders or their families can call to find out about nursing homes in their areas.

Will the price go up?

As with life insurance, the older you are when you buy the policy, the more expensive it is. A 75-year-old buying Great Republic's long-term-care policy will pay $3143 a year. A 55-year-old can buy the same policy for $611 a year.

In most cases, the premiums remain "level"—they don't increase after someone buys the policy. (Premiums that do increase annually or every few years as the policyholder grows older make a policy far less desirable.)

But a level premium is not necessarily as level as it looks. A company can increase a so-called level premium on your policy provided it also increases the premium for everyone else in your state who bought the same policy.

One CONSUMER REPORTS reader wrote us about his experience with a policy from Massachusetts Indemnity and Life: The

Continued on page 10

Guide to the Ratings

Listed in order of estimated overall quality. Within red rules, plans were judged approximately equal in quality.

1 Premium. Premium paid at age 65, expressed as a monthly amount for the purposes of the Ratings.

2 Daily benefit. The amount of money a policy pays for each day spent in a covered care facility.

3 Waiting period. The number of days a policyholder must be in a facility before coverage actually begins.

4 Each period. The number of days a policy pays for one stay in a nursing home. Some policies have dollar maximums instead.

5 All periods. The number of days a policy pays for all nursing-home stays.

6 Skilled. Policy pays benefits for care in a skilled-nursing facility.

7 Intermediate. Policy pays benefits for care in an intermediate-nursing facility.

8 Custodial. Policy pays benefits for care in a custodial-nursing facility. Care is usually limited to helping people perform routine activities.

9 Home care. Policy pays benefits for care at home.

10 No prior hospitalization. Most policies require a hospital stay of at least three days before entering a nursing home. Policyholder must also enter nursing home within 30 days of hospital discharge. A — indicates the policy has a prior-hospitalization rule. Variations of this rule are listed under advantages and disadvantages.

11 Alzheimer's coverage. The policy language specifies that Alzheimer's disease is covered.

12 Inflation adjustment. An optional rider or other arrangement which increases benefits by a set percentage each year for a certain number of years.

13 Preexisting conditions. Policy covers care for preexisting conditions—ailments or illnesses a policyholder has at the time a policy is issued.

14 Level premiums. A premium that doesn't increase with the age of a policyholder is highly desirable.

15 Guaranteed renewable. Company will always renew coverage each time the premium is paid. Without this protection, a company can usually cancel the policy if it cancels all other policies of that type in a state.

16 Waiver of premium. Feature allows policyholders to stop paying premiums once they've been in a nursing home for a certain period, usually 90 days.

17 Rejection rate. The percentage of applicants rejected by a company. A — indicates company provided no information.

18 Substandard risks. Someone who has health problems can buy insurance with a higher premium, **P**, or a waiver, **W**, that excludes coverage for those problems. Waivers are undesirable.

Ratings

Nursing-home insurance

Company name	1 Premium	2 Daily benefit	3 Waiting period	Maximum benefit: 4 Each period	5 All periods	Type of facility: 6 Skilled	7 Intermediate	8 Custodial	9 Home care	10 No prior hospitalization	11 Alzheimer's coverage	12 Inflation adjustment	13 Preexisting conditions	14 Level premiums	15 Guaranteed renewable	16 Waiver of premium	17 Rejection rate	18 Substandard risks	Advantages	Disadvantages
Great Republic with Skilled Care at Home Rider 206-285-1422	$ 87.50 [1]	$ 80	20	unlimited	unlimited	[2]	✔	✔	✔	—	✔	✔	✔	✔	✔	10%	—	B,E	I	
John Hancock Mutual Life Protectcare - Individual 817-421-6000	76.52 [1]	100	20	2190	2190	✔	[4]	[3]	✔	✔	✔	✔	—	✔	✔	✔	20-25	—	A,C	—
American Progressive Life & Health 800-243-9214	57.24	80	20	1095	1825	✔	✔	[4]	✔	—	—	—	—	✔	✔	✔	5	—	—	—
Bankers Life and Casualty with Home Health Care Benefit Rider 312-777-7000	53.54	50	20	1095	unlimited	✔	✔	✔	✔	—	✔	✔	—	✔	✔	✔	10	—	—	—
Bankers Multiple Line with Home Health Care Benefit Rider 312-777-7000	53.54	50	20	1095	unlimited	✔	✔	✔	✔	—	✔	✔	—	✔	✔	✔	10	—	—	—
Certified Life with Home Health Care Benefit Rider312-777-7000	53.54	50	20	1095	unlimited	✔	✔	✔	✔	—	✔	✔	—	✔	✔	✔	10	—	—	—
Union Bankers with Home Health Care Benefit Rider312-777-7000	53.54	50	20	1095	unlimited	✔	✔	✔	✔	—	✔	✔	—	✔	✔	✔	3	—	—	—
Equitable Life and Casualty 800-453-3249	52.56	60	30	3650	$250,000	✔	✔	✔	[9]	✔	—	—	—	✔	✔	✔	7	—	—	I
Life Insurance Co. of Connecticut 800-645-9876	88.04	80	20	1095	1825	✔	✔	[4]	✔	—	—	—	—	✔	✔	✔	5	—	—	I
Metropolitan Life Group Policy for Williamsburg Landing 212-578-2211	95.00 [2]	46 [5]	60	unlimited	unlimited	✔	✔	✔	✔	✔	✔	✔	✔	—	—	—	10	P	D,F	b,e,h
Fenwest American Assurance Co. 503-224-7740	50.67	80	20	1460	2190	✔	✔	[4]	✔	✔	✔	✔	—	✔	✔	✔	12	—	A	—
Bankers Life and Casualty without Home Health Care Benefit Rider 312-777-7000	36.30	50	20	1095	unlimited	✔	✔	✔	—	—	—	✔	✔	✔	✔	✔	10	—	—	—
Bankers Multiple Line without Home Health Care Benefit Rider 312-777-7000	36.30	50	20	1095	unlimited	✔	✔	✔	—	✔	✔	✔	✔	✔	✔	✔	10	—	—	—

[1] *Represents one-twelfth of company's annual premium. Monthly premium, if available, would probably be higher.*

[2] *Composite rate means the company charges the same premium at all ages.*

[3] *Represents weekly premium.*

[4] *Benefit paid for one person; policy pays $60 for first spouse of a couple living together.*

[5] *Pays 80 percent of actual charge with maximum policy payment of $80 a day.*

[6] *Pays 100 percent of actual cost.*

[7] *Pays for "usual and customary" charges up to a maximum of $50.*

[8] *Pays 100 percent of "eligible" charges up to a maximum of $75.*

[9] *Pays this for skilled care, pays $50 for intermediate care and $25 for custodial care.*

[10] *Pays 75 percent of charges based on negotiated rates with participating provider.*

[11] *Daily equivalent of company's $2000 a month benefit.*

[12] *Pays half benefits for first 50 days, but waiting period does not apply.*

[13] *Pays for custodial care only.*

[14] *Depends on company's interpretation.*

[15] *Shorter benefit period.*

[16] *Reduced daily benefit.*

[17] *Only after 14 days skilled-nursing care.*

[18] *Benefits paid only after pre-confinement in skilled or intermediate facility; benefits are reduced and paid over a shorter period.*

Key to Advantages

A – No prior hospitalization required; company does not arbitrarily decide whether policyholder requires nursing-home care.
B – Built-in inflation adjustment.
C – Toll-free number available to policyholders needing help with nursing-home selection.
D – Care coordinator available to help policyholders find nursing homes.
E – Intermediate or custodial care must follow either hospital confinement of two days or skilled confinement of 10 days.
F – Benefit represents 100 percent of incremental cost for retirement-home resident.
G – Product operates according to HMO service-provided principles.
H – Will verify that institution complies with group certificate language as a covered facility.
I – Must check into nursing home within 90 days of discharge from hospital.
J – Company has large variety of home-care coverages available in separate policy or rider.

Key to Disadvantages

a – Policyholder must check into nursing home within 14 days of discharge from a hospital—a very short time for decisions.
b – Company arbitrarily decides whether policyholder requires nursing-home care.
c – Has premiums that go up annually as policyholder gets older.
d – Has premiums that go up every few years.
e – Conditionally renewable, or group insurance contract.
f – Must remain in retirement community group to keep coverage.
g – Pays for custodial care that takes place in a skilled or intermediate facility.
h – Intermediate facilities and custodial facilities (Personal Care Homes) must be on site and owned by retirement community.
i – Pays only if the facility qualifies, irrospective of level of care.
j – Pays for intermediate or custodial care that takes place only in a skilled facility.
k – Pays for skilled, intermediate, or custodial nursing care only in a skilled facility.
l – Company has Best's rating of B or lower, or is not assigned by Best's.

Ratings of Nursing-home insurance

Continued

Company name	1 Premium	2 Daily benefit	2 Waiting period	4 Each period	5 All periods	Maximum benefit: 6 Skilled	Maximum benefit: 2 Intermediate	Type of facility: 9 Custodial	Type of facility: 9 Home care	10 No prior hospitalization	11 Alzheimer's coverage	12 Inflation adjustment	13 Preexisting conditions	14 Level premiums	15 Guaranteed renewable	16 Waiver of premium	17 Rejection Rate	18 Substandard	Advantages	Disadvantages
Certified Life without Home Health Care Benefit Rider 312-777-7000	$ 36.30	$50	20	1095	unlimited	✓	✓	✓	—	—	✓	✓	—	✓	✓	10%	—	—	—	
Union Bankers without Home Health Care Benefit Rider 312-777-7000	36.30	50	20	1095	unlimited	✓	✓	✓	—	—	✓	✓	—	✓	✓	3	—	—	—	
John Hancock Mutual Life Flex Plan 88 - Group Policy 617-421-6000	16.11 [3]	[5]	90	1460	1460	✓	[4]	✓	✓	✓	✓	✓	—	✓	✓	✓	5-10	—	*D*	b
Group Health Cooperative of Puget Sound Security Care Agreement of Metropolitan Life 212-578-2211	80.00	[5]	30	1460	1460	✓	✓	✓	✓	✓	✓	✓	✓	—	—	20-30	—	*D,G*	b,e
World Life & Health of Pennsylvania 800-523-1280	53.75 [1]	50	0	730	unlimited	✓	✓	✓	✓	—	—	—	✓	✓	✓	3	P,W	*C*	i
Transport Life 817-390-8060	89.56	80	0	1460	$204,400	✓	✓	✓	✓	—	—	—	✓	—	✓	3-5	—	*H*	*e*
AMEX Life 415-482-7000	33.00 [3]	55	20	1460	1460	✓	✓	[14]	✓	—	✓	✓	—	✓	✓	10-20	—	*C,I*	—
Aetna Life and Annuity Long Term Care Plan 203-273-0123	33.02	50	20	1460	1460	✓	✓	[14]	✓	—	—	✓	—	✓	✓	10	—	*C*	—
Reserve Life 214-870-9700	37.32	60	100	1095	1095	✓	✓	[14]	✓	—	—	—	—	✓	✓	5	—	—	—
Acceleration Life 614-764-7000	83.16	80	100	1825	1825	✓	✓	✓	✓	—	—	—	✓	—	✓	3	W	—	e
MidAmerica Mutual Life with Prior Hospitalization 612-331-8370	67.20	60	20	$60,000	$60,000	✓	✓	✓	✓	—	✓	—	—	✓	✓	—	—	—	c
Continental Casualty with Home Health Care Rider 312-822-5000	43.25	60	15	1825	2555	✓	✓	—	✓	—	—	✓	✓	✓	✓	15	P	—	g
Harvest Life 616-968-7200	44.22	50	20	1095	1825	✓	✓	✓	✓	—	—	—	—	✓	✓	1	—	—	e
Mutual Protective 402-391-6900	43.95 [1]	60	20	1095	1460	✓	✓	—	✓	✓	✓	—	—	✓	✓	17	P	*A,C*	h
Continental Casualty without Home Health Care Rider 312-822-5000	38.40	60	15	1825	2555	✓	✓	—	—	—	—	✓	✓	✓	✓	15	P	—	g
MidAmerica Mutual Life without Prior Hospitalization 812-331-8370	78.60	60	20	$100,000	$100,000	✓	✓	✓	✓	✓	—	—	—	✓	✓	—	—	*A*	c
Prudential, American Association of Retired Persons (available April, 1988) 800-523-5800	55.00	50	90	1095	1095	✓	✓	✓	✓	✓	—	✓	✓	✓	✓	—	—	*A,C*	—
Federal Home Life 800-253-0856	42.50 [1]	50 [7]	20	1095	1825	✓	✓	✓	✓	—	—	—	—	✓	✓	1	—	—	e
Blue Cross of Washington and Alaska 800-231-9518	69.58 [1]	75 [8]	20	2190	2190	✓	✓	✓	✓	✓	✓	—	—	✓	✓	20-22	—	*D*	b
AIG Life Group Long Term Care Certificate with Extended Home Care Rider 302-594-2000	68.20	60	20	1825	1825	✓	—	—	✓	—	✓	—	✓	✓	✓	20	—	*D*	i
American Travellers Life without Supplemental Home Health Care Policy 215-343-1000	24.30	50	0	730	730	✓	[9]	[15]	—	—	—	—	✓	✓	—	2-4	P	*J*	a,l
NN Investors Life with Home Health Care Rider 800-338-0257	37.80	60	20	1000	1500	✓	✓	—	✓	—	—	—	✓	✓	✓	13	P	*C*	g
Columbia Life 717-784-2716	42.50	50	20	1460	1460	✓	[9]	[15]	—	✓	—	—	✓	✓	✓	2	P,W	*A*	i
Travelers Long Term Care Plan Trust 203-277-0111	66.75	50	90	$75,000	$75,000	✓	✓	[14]	✓	✓	✓	—	✓	✓	✓	—	—	*A,C*	g
American Republic with Home Health Care Benefit 515-245-2000	66.42	60	60	$90,000	$90,000	✓	✓	—	✓	✓	✓	—	✓	✓	✓	15	—	*A,C*	g
NN Investors Life without Home Health Care Rider 800-338-0257	29.16	60	20	1000	1500	✓	✓	—	—	—	—	—	✓	✓	✓	13	P	*C*	g
Penn Treaty Life with Supplemental Coverage for Home Health Care 800-222-3469	75.19	50	0	730	730	✓	✓	✓	✓	—	—	—	✓	✓	✓	10	P,W	—	e,l
Prudential, American Association of Retired Persons (Previous Plan) 800-523-5800	48.75	50	90	1095	1095	✓	✓	✓	✓	✓	✓	—	✓	—	✓	8	—	*C*	e
American Republic without Home Health Care Benefit 515-245-2000	58.44	60	60	$90,000	$90,000	✓	✓	—	—	✓	✓	—	✓	✓	—	15	—	*A,C*	g
Colonial Penn Life 800-523-4000	55.15 [1]	60	20	1095	unlimited	✓	✓	—	✓	—	—	—	✓	✓	✓	2	—	—	g
Gerber Life 914-761-4404	39.59	75 [9]	100	1825	$187,500	✓	[13] [16]	[13] [16]	—	—	—	—	✓	✓	—	—	—	—	e
Finger Lakes Long Term Care, Subsidiary of Blue Cross and Blue Shield of Rochester 716-454-1700	102.56	[10]	100	1825	1825	[11]	[11]	[13]	✓	✓	✓	✓	—	✓	✓	✓	30	—	*D*	b
American Sun Life with Home Convalescent Policy 305-647-3111	56.81	60	0	1095	unlimited	✓	—	—	✓	—	—	—	—	—	✓	—	—	—	*d,e,k,l*	
United General Life with Home Convalescent Care Coverage 813-544-8881	39.83 [1]	60	0	730	unlimited	✓	—	—	✓	—	—	—	—	—	✓	10 or less	—	—	*j,c,l*	
Pilgrim Life Three Diamond Plan with Home Private Duty Nursing Benefit of $100 per day 215-534-8800	65.19	67 [12]	0	730	730	✓	✓	✓	✓	—	—	—	✓	—	—	1	P	—	e,l	
Penn Treaty Life without Supplemental Insurance Coverage for Home Health Care 800-222-3468	52.24	50	0	730	730	✓	✓	✓	—	—	—	—	✓	✓	✓	10	P,W	—	a,l	
American Sun Life without Home Convalescent Policy 305-647-3111	31.32	60	0	1095	unlimited	✓	—	—	—	—	—	—	—	—	✓	—	—	—	*d,e,k,l*	
Pilgrim Life Three Diamond Plan without at Home Private Duty Nursing 215-534-8800	52.20	67 [12]	0	730	730	✓	✓	✓	—	—	—	—	✓	—	—	1	P	—	e,l	
Life and Health of America 215-567-1248	100.00	40	20	730	730	✓	✓	✓	—	—	—	✓	✓	✓	—	2	—	—	a	
United General Life without Home Convalescent Care Coverage 813-544-8881	28.08 [1]	60	0	730	unlimited	✓	—	—	—	—	—	—	—	—	✓	10 or less	—	—	*j,c,l*	

Key to Advantages

A – No prior hospitalization required; company does not arbitrarily decide whether policyholder requires nursing-home care.
B – Built-in inflation adjustment.
C – Toll-free number available to policyholders needing help with nursing-home selection.
D – Care coordinator available to help policyholders find nursing homes.
E – Intermediate or custodial care must follow either hospital confinement of two days or skilled confinement of 10 days.
F – Benefit represents 100 percent of incremental cost for retirement-home resident.
G – Product operates according to HMO service-provided principles.
H – Will verify that institution complies with group certificate language as a covered facility.
I – Must check into nursing home within 90 days of discharge from hospital.
J – Company has large variety of home-care coverages available in separate policy or rider.

Key to Disadvantages

a – Policyholder must check into nursing home within 14 days of discharge from a hospital—a very short time for decisions.
b – Company arbitrarily decides whether policyholder requires nursing-home care.
c – Has premiums that go up annually as policyholder gets older.
d – Has premiums that go up every few years.
e – Conditionally renewable, or group insurance contract.
f – Must remain in retirement community to keep coverage.
g – Pays for custodial care that takes place in a skilled or intermediate facility.
h – Intermediate facilities and custodial facilities (Personal Care Homes) must be on site and owned by retirement community.
i – Pays only if the facility qualifies, irrespective of level of care.
j – Pays for intermediate or custodial care that takes place only in a skilled facility.
k – Pays for skilled, intermediate, or custodial nursing care only in a skilled facility.
l – Company has Best's rating of B or lower, or is not assigned by Best's.

[1] *Represents one-twelfth of company's annual premium. Monthly premium, if available, would probably be higher.*
[2] *Composite rate means the company charges the same premium at all ages.*
[3] *Represents weekly premium.*
[4] *Benefit paid for one person; policy pays $60 for first spouse of a couple living together.*
[5] *Pays 80 percent of actual charge with maximum policy payment of $80 a day.*
[6] *Pays 100 percent of actual cost.*
[7] *Pays for "usual and customary" charges up to a maximum of $50.*
[8] *Pays 100 percent of "eligible" charges up to a maximum of $75.*
[9] *Pays this for skilled care, pays $50 for intermediate care and $25 for custodial care.*
[10] *Pays 75 percent of charges based on negotiated rates with participating provider.*
[11] *Daily equivalent of company's $2000 a month benefit.*
[12] *Pays half benefits for first 50 days, but waiting period does not apply.*
[13] *Pays for custodial care only.*
[14] *Depends on company's interpretation.*
[15] *Shorter benefit period.*
[16] *Reduced daily benefit.*
[17] *Only after 14 days skilled-nursing care.*
[18] *Benefits paid only after pre-confinement in skilled or intermediate facility; benefits are reduced and paid over a shorter period.*

Insurance regulators look the other way

Every state has a department of insurance that's supposed to protect consumers by regulating the insurance policies sold in that state and by supervising the activities of insurance companies. But with few exceptions, regulators are reluctant to look too closely at long-term-care insurance policies, for fear that insurance companies will refuse to provide any coverage at all rather than tailor coverage to meet stern regulatory requirements.

"We are treating long-term care differently than other lines of insurance," says Fred Bodner, chief of the New York Insurance Department's Health and Life Policy Bureau. "We're not going to approve a policy if it's a rip-off, but we're not going to turn it down if it isn't wonderful."

The National Association of Insurance Commissioners (NAIC), which writes model laws for all states to adopt, has written one for long-term-care policies. So far, 11 states have adopted this model, and companies selling policies in these states must comply with its provisions.

States in which insurance policies must meet the NAIC standards are: Arizona, Hawaii, Indiana, Iowa, Kansas, Nebraska, North Carolina, North Dakota, Oklahoma, Oregon, and Virginia. Wyoming and Georgia were about to adopt the model law as we went to press.

The model has some good rules. Waivers denying coverage for specified health conditions are prohibited, and companies cannot offer substantially greater benefits for skilled nursing care than for custodial and intermediate care. Policies must also be guaranteed renewable, but state insurance commissioners may allow cancellation in limited circumstances.

The NAIC model permits other features we consider undesirable: Companies can require a hospital stay before providing benefits for nursing-home care, and can require that a policyholder receive skilled care before qualifying for intermediate, custodial, or home-care benefits. Although the NAIC model prohibits companies from excluding coverage for Alzheimer's disease, it doesn't require policies to specifically spell out that the disease is covered.

Not addressed by the NAIC model law is the need for standard language for long-term-care policies, much like the standard language found in a homeowners policy. Without it, consumers will be forced to rely on confused agents and equally confusing sales brochures.

When CU asked all 50 state-insurance commissioners what complaints had developed from the sale of long-term-care insurance, we learned that consumers complained most often about the unanticipated limitations on the coverage provided by their policies. Consumers believed that their policies covered them for a particular kind of care when, in fact, no such coverage existed.

Members of the NAIC advisory committee that wrote the model law considered requiring companies selling long-term-care policies to include the telephone number of the state-insurance department on forms given to policyholders who are thinking about replacing their policies. That way consumers could call their state regulators if they couldn't decipher a policy. But the committee scrapped the idea when insurance companies argued it would not provide a substantial benefit to consumers.

If insurance regulators don't help buyers of long-term-care policies, who will?

premium for his long-term-care policy had jumped a whopping 150 percent, from $180 to $450, in a single year.

Long-term-care policies don't have much of a history. As a result, insurance-company actuaries may be unable to predict nursing-home use or future costs accurately. Some insurance companies may be pricing their policies too low to cover the promised benefits in the future.

Are you insurable?

Someone who's sick and ready to check into a nursing home can't buy a policy from most companies. Many insurance companies have instructed their agents to weed out "undesirables" before applications reach the home office. If an agent sees that a person can't get out of bed alone or learns that a person has osteoporosis or Alzheimer's disease, the agent won't even deliver a sales pitch. An Aetna agent in Virginia told our reporter that she had to come to his office to hear the sales presentation, probably to see whether she could actually walk.

People who are turned down for life or health insurance might nevertheless be good risks for long-term-care insurance. "Someone with terminal cancer may be a better risk than someone with mild arthritis," says Karl Michaelson, director of health-products underwriting for Aetna. "We do not like to insure people who need aids in getting around—like walkers, canes, and oxygen."

Some companies are choosier than others. Rejection rates vary from 1 percent for Harvest Life, Pilgrim Life, and Federal Home Life to 30 percent for Finger Lakes Blue Cross/Blue Shield.

Many companies offer coverage to people with less-than-perfect health by applying "waivers," which exclude coverage for certain conditions. But buying a policy with a waiver for an illness that's likely to land you in a nursing home is a waste of money.

Instead of waivers, some companies offer coverage at higher rates to people who have health problems. Depending on the severity of the illness or condition, a "substandard risk" could pay as much as 100 percent more than a person whose health qualified him or her for the company's standard rate.

Evaluating the policies

We requested data from 81 insurance companies that sell long-term-care policies or that will start to offer them in the near future. Some told us they were withdrawing their policies and wouldn't have new ones ready in time for us to evaluate. Several companies, including Mutual of Omaha, United American, Combined American Life Insurance Co., American Integrity, National States Life, and Central

States Health and Life, declined to provide the information we requested. (We obtained policies and rate information on some of those companies from state insurance departments, but decided not to include these policies in the Ratings, because the data are incomplete.)

We've listed several policies twice, once with their home-care provisions and once without them. We've included two policies sold by MidAmerica Mutual Life, as well as both the old and new policies underwritten by Prudential for the American Association of Retired Persons.

The Ratings show the plans based on the daily benefit amounts and waiting periods that companies said were selected most often by their customers. If a company didn't tell us which of its plans was most popular, we chose one.

Some of the policies are group policies that have the same characteristics as individual policies. Policies sold by AARP are an example.

To rank the policies, we paid special attention to six main features that contribute to a policy's overall quality: nursing-facility coverage, home-care benefits, restrictions, renewability, relationship of benefits to premium and other aspects of pricing, and underwriting (the process of selecting applicants for coverage). We assigned the most points for quality of coverage and absence of restrictions. We also give bonus points to policies with liberal home-care provisions.

We also examined each company's financial stability, as judged by the A.M. Best Co., which rates insurance companies from A+ (superior) to C (fair). If a company's Best's rating is B or poorer (or if the company is not assigned a rating), we've considered it a disadvantage, since a low rating suggests some risk the company may not be around to pay future benefits.

Should you buy?

We don't recommend long-term-care policies for anyone under age 60 unless the policy offers a good way to keep benefits current with inflation in nursing-home costs. For those over age 60, a policy from one of the top-rated companies might be a reasonable choice. People whose income and assets are fairly modest should not buy long-term care policies. They would quickly qualify for Medicaid benefits should they need to stay in a nursing home.

The best policies cover care in all three types of nursing facility and offer generous daily benefits and benefit periods. They also have a good price in relation to those benefits.

Even the best policies had minor deficiencies in their coverage, however. For example, the Great Republic policy has a generous $80 benefit, paid for an unlimited period. But the policy restricts the benefit to a lower amount for the first 50 days of skilled care. It compensates for that restriction somewhat by not requiring a waiting period before paying benefits. And it is the only policy with a built-in inflation adjustment, a highly desirable feature.

The John Hancock policy offers a generous $100 benefit for six years, a period that should cover most nursing home stays, and its coverage has only a few minor limitations. Buying the policy could be a problem, however. The company estimates its rejection rate at 20 to 25 percent. A company spokesperson says that this rejection rate could drop as John Hancock agents acquire more experience selling the policy.

The most popular policies sold by Bankers Life and Casualty and its subsidiaries, Bankers Multiple Line, Certified Life, and Union Bankers, offer coverage for care in all three types of facility, and the policy specifically says Alzheimer's disease is covered. But these policies ranked somewhat below the top companies because of their relatively low daily benefit ($50), which is available for only three years for each nursing home stay.

A high premium doesn't always buy higher-quality benefits. For example, compare the American Progressive Life policy with the Life and Health of America policy, which ranked next to last.

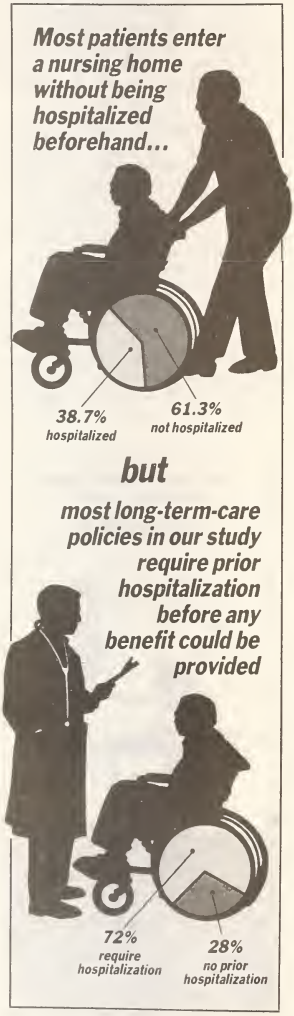
The former provides an $80 daily benefit for a monthly premium of $57.24. The policy offers benefits for three years for one nursing-home stay and five years for all stays. The Life and Health policy offers a skimpy $40 daily benefit (for only two years) yet commands a $100 premium.

Buying a policy through a group doesn't necessarily mean you'll get more for your money. Neither the policy recently sold through the American Association of Retired Persons nor the policy that will replace it this spring ranked highly. They impose a 90-day waiting period before nursing-home benefits begin and pay benefits for only three years. (Visits by home-health-care workers count toward satisfying the 90-day waiting period.) Neither policy, however, requires a stay in a hospital before benefits start.

The old AARP policy has no provision to continue coverage if the group contract is cancelled; the new one does. An AARP spokesperson says that people who have bought the old policy have assurances from AARP that coverage won't end.

Insurance companies have come up with some innovative ideas. For example, Metropolitan's Security Care Agreement for Group Health Cooperative of Puget Sound provides service in accordance with the principles of a health maintenance organization. Patients receive service instead of dollar benefits. Since the benefits offered by this plan will cover 100 percent of the actual cost of nursing-home care, they should hold up well against inflation.

This plan did have its drawbacks. It paid benefits for a relatively short time (4 years), lacked a waiver of premium, and had a high estimated rejection rate (20 to 30 percent).



Must you die poor?

Mary Ann Mattingly, of Indianapolis, looked forward to a comfortable old age when her husband James retired from his job as a security guard at the Eli Lilly Co. The Mattinglys lived reasonably well on the $744 a month he received from his company pension plan and from Social Security. They even managed to dine out on occasion.

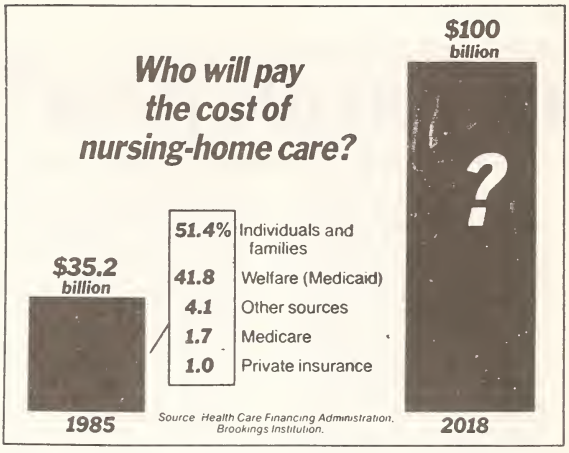
But James's health slowly began to deteriorate. He became confused. He could no longer walk. He needed someone to help him eat. In 1979, at the age of 72, he checked into the Eastside Health Care Center, an Indianapolis nursing home. By the time James died in 1986, the Mattingly family, despite a lifetime of work and the security of a pension, had sunk into poverty. It was either that or do without the care James needed in his final years.

James's first year in the nursing home cost $12,000—about $3000 a year more than the family's total annual income. Mary Ann applied for help from Medicaid, the Federal and state program that helps the poor pay their health-care bills. She learned she was too rich for Indiana's Medicaid program. The Mattinglys had accumulated $5000 of Eli Lilly stock, $3000 in a passbook savings account, $2000 in life-insurance cash value, $5000 in a certificate of deposit, and $300 in a Christmas-club savings plan.

The only way Mary Ann could keep James in a nursing home was to become impoverished. Medicaid pays the bills only after the family assets and income run out. That usually doesn't take long. On average, 13 weeks elapse from the time a patient is admitted to a nursing home until the spouse left at home is impoverished. It took Mary Ann Mattingly only nine months to spend on nursing-home care most of what the family had accumulated. When she was poor enough, Medicaid stepped in.

Each state has its own Medicaid rules. Indiana allowed Mary Ann to keep $2250 of her family's assets plus her household furnishings. (If she'd owned a home, she could have kept that, too.) But nursing-home care still took $477 a month of the Mattinglys' $744 monthly income, leaving $238 to cover rent, gasoline and insurance for the car, and food, and $29 for James's incidental expenses.

Once she became poor, Mary Ann, who had never taken a hand-out in her life, qualified for food stamps—as much as $75 worth a month, but more often $30 worth.



Special Federal funds to help poor people pay for utilities sometimes paid for her heating bills.

The Medicaid rules did give Mary Ann one way to protect her assets and avoid poverty: divorce. After 32 years of marriage, she wouldn't consider it.

"It was horrible," says Mary Ann. "There's still anger in me. Nobody can understand until they've experienced it. A lot of people today don't know what they have in store." Indeed they may not.

In the year 2030, people over 65 will make up 21 percent of the population, up from 12 percent in 1985. The fastest-growing age group is the "old-old," people 85 and older. Their need for long-term care is greatest.

Nursing-home costs have gone up almost as fast as the age of the population. The average annual cost of a year's stay in a nursing home is now about $22,000, but the cost rises to as much as $45,000 in metropolitan areas such as New York City. Medicaid pays for nearly half of those stays. Federal expenditures for nursing-home care grew tenfold from 1965 to 1980 and will quadruple by 1990.

For years, health economists and social-service planners have seen the shadow of these costs looming. But long-term care for the elderly has only recently won a place on the national agenda—as a seemingly intractable problem for the debt-ridden Federal government, as a giant financial headache for state governments that share the cost of the Medicaid program, as a painful crisis for more and more families, and lately as a marketing opportunity for insurance companies.

What to do?

In 1986, the Secretary of Health and Human Services, Dr. Otis Bowen, issued a report pointing out that Medicare, the health-insurance program for the elderly,

did not protect people from the high costs of a catastrophic illness. The report focused attention on the financial consequence of stroke, heart attack, and other medical catastrophes. The reaction to the report spurred Congress to pass bills expanding Medicare to include coverage for catastrophic illnesses of *limited* duration.

But none of the bills do anything to help families pay for long-term care—the greatest source of economic catastrophe. Eighty percent of health-related costs that exceed $2000 a year are due to nursing-home and other long-term-care expenses.

Who then will pay?

The Reagan Administration's answer, echoed by the health-insurance industry: Consumers should buy long-term-care insurance policies, of the type rated in the accompanying report. That set off a small boom in this new insurance product. Unfortunately, few of the insurance policies we looked at adequately meet the need. And the cost of these policies—as much as $1230 a year for a 65-year-old—may well be beyond the means of those who need protection most.

Even those who can afford such policies for themselves or for their parents may find insurers unwilling to sell, usually because the person to be insured is already a candidate for a nursing home. Insurance companies aren't eager to insure people who are almost certain to generate a claim. A few companies in our survey estimated that they turned down as many as 20 or even 30 percent of potential buyers.

Insurance companies would prefer to market their policies to employers, who in turn would offer them to their employees, thus encouraging younger people to buy the insurance when they are still insurable and when the rates are low.

But private insurance for long-term care is a tough sell to employers and employees alike. Employers, some of whom already face huge liabilities for current and former employees' conventional health insurance, are unlikely to pick up the tab for yet another kind of insurance now or in the near future. At most companies that do offer long-term-care insurance, employees must pay the entire premium. But healthy workers either do not know what's ahead for them (estimates are that as many as one of every two people who reach age 65 will eventually land in a nursing home) or prefer not to think about it just yet. When Aetna Life Insurance Co. offered long-term-care coverage to its own employees, only 7 percent bought it. Ten percent of its retirees signed up.

A recent study by the Brookings Institution, using generous assumptions about people's ability to pay for long-term-care policies, predicted that by the year 2018 private insurance would cover only 7 to 12 percent of all nursing-home expenses. Brookings researchers believe that, at best, only one-quarter to one-half of the elderly would buy long-term-care policies.

Thus, for many low- and middle-income families, Medicaid and its prerequisite—spousal impoverishment—will remain the only feasible way to pay for long-term care, unless we find a better way.

Expanding the safety net

Soon the Federal government—and American taxpayers—will have to face the increasingly urgent need for a new social-insurance program that helps chronically ill and disabled people with the costs of long-term care before those costs impoverish them.

The need for universal long-term-care protection can be met through a new mandatory insurance program that complements Medicare and replaces the long-term-care portion of Medicaid. Or the current Medicare program could be expanded to include voluntary insurance paid for by premiums charged to participants.

The private insurance system can't spread its costs over a large enough number of people to minimize the financial burden on any one person. Only the Federal government can do that. Funding long-term-care insurance through general revenues spreads the cost among everyone who's a future candidate for long-term care. And making the insurance available to (and required of) everyone eliminates the eligibility standards that now effectively withhold private insurance from those who need it most. A Federally mandated insurance program would also eliminate Medicaid nursing-home coverage, and with it the costs and stigma associated with Medicaid.

So far, however, the only long-term care proposal to surface in Congress addresses long-term care only at home, not in a nursing home. A bill introduced by Claude Pepper, the Democratic Congressman from Florida, would provide a range of home-care, physical-therapy, and homemaker services to the chronically ill elderly and to disabled people of all ages. It would be financed by applying that portion of Social Security taxes that pays for Medicare (1.45 percentage points) to all earned income rather than to the first $45,000 of income, as at present. Some 5 percent of American workers earn more than $45,000 a year; they pay a proportionally smaller tax for Social Security and Medicare than do the great majority of workers who earn $45,000 or less.

Although the Pepper bill, if it passes, may help keep some ill or disabled people out of institutions, it is only a first step toward correcting a health-insurance system that forces too many people into poverty. The bigger step—universal coverage for long-term care no matter where the service is rendered—remains to be taken. ■

What's available now

Program	*Nursing home*	*Home care*
Medicare	Skilled-nursing care covered only in approved facilities: 100% of eligible expenses for 20 days; all but $67.50 a day for next 80 days; nothing after that; no custodial or intermediate care.	Only part-time, intermittent skilled care and speech or physical therapy covered. Person must be confined to home and care-provider must agree to reimbursement under Medicare rules.
Medicaid	Skilled, intermediate, and custodial care covered once a person's assets and income drop below state Medicaid limits.	Part-time nursing and home-health aids provided if requested by physician for those eligible for Medicaid. States have the option to offer a variety of non-medical home-care services.
Medicare supplement policies	Benefits range from nothing to the policy limits for sharing the cost of care for days 21-100; after that, policies pay a set amount each day. Custodial or intermediate care usually not covered.	Usually nothing covered.
Ordinary health insurance policies	Very limited post-hospital, convalescent, skilled-nursing care covered, but usually no custodial or intermediate care.	Very limited post-hospital convalescent care may be covered
Veterans Administration	Skilled-nursing care provided only in VA facilities on a space-available basis for eligible veterans.	Chronically ill eligible veterans, eligible for medical, nursing, and rehabilitative care.

Chairman STARK. Thank you.
Miss Bedford.

STATEMENT OF GWENDOLYN M. BEDFORD, MEMBER, BOARD OF DIRECTORS, AMERICAN ASSOCIATION OF RETIRED PERSONS

Ms. BEDFORD. Thank you, Mr. Chairman.

On behalf of the American Association of Retired Persons, I want to thank you for this opportunity to discuss the need for Federal regulation of long-term care insurance. AARP strongly supports Federal minimum standards for long-term care insurance, and we believe your bill, H.R. 1325, represents an important step toward protecting consumers by assuring more uniform and adequate regulation of this relatively new product.

AARP believes that the development of this market over the past several years demonstrates that private insurance can help some people, but that its potential for meeting the long-term care need is limited. We believe that it is essential for the Federal Government to play a much stronger role in financing long-term care.

There is a need for a comprehensive public long-term care program based on the principles of social insurance and shared risk, similar to H.R. 5393, which you introduced last session. Under such a social insurance system, private sector approaches can and should supplement the public system.

Cost and underwriting restrictions, for example, severely limit the number of people who can benefit from private insurance. Long-term care insurance premiums tend to be steep—especially for policies with meaningful benefits which keep pace with inflation. Cost-sharing requirements, deductibles and coinsurance, are also expensive.

Even with recent improvements, most policies on the market today have restrictions and exclusions that limit their effectiveness. Unfortunately, these specific shortcomings have an even greater impact on buyers because they often fail to understand the significance of these restrictions until after they need care.

AARP believes that Federal oversight of the long-term care insurance industry is necessary. Federal standards could play a valuable role in consumer protection by, first, assuring that long-term care insurance is marketed and sold in a fair and informative manner; second, by eliminating certain limitations and restrictions that cause confusion and reduce the value of policies; and third, requiring that policies meet certain minimum standards of coverage.

We believe a Federal/State approach, not unlike that of the Baucus amendment for medigap policies, is important to prevent abuses associated with long-term care insurance and to ensure that consumers in all 50 States have this protection.

AARP also supports Federal involvement in long-term care data collection and analysis. Such a national and coordinated data collection system could substantially improve the quality and quantity of information about long-term care service use, the price, distribution, and effectiveness of long-term care insurance, as well as its impact on Government program expenditures. A comprehensive Federal information system would assist States and the Federal Government in regulating and monitoring this developing market

to assure that buyers receive a fair return on their insurance investment.

H.R. 1325 proposes several significant standards which, when added to the requirements of the NAIC model standards, would increase consumer protection. In particular, AARP strongly supports the provision in H.R. 1325 which prohibits conditioning any benefit on prior receipt of hospital or nursing home care. The requirement that insurers offer buyers the option of purchasing home and community-based benefits also is significant.

In addition, we have identified a number of other standards and provisions which we feel are necessary to increase consumer protection and understanding.

The biggest limitation in many current long-term care insurance policies is their failure to assure meaningful protection over time. Insurers should be required to offer insureds an option to increase benefits to reflect increases in long-term care service costs.

Long-term care insurance policies should also have a nonforfeiture provision. At a minimum, policies should vest some portion of benefits if the insurer increases the premium, or otherwise is able to change the terms of coverage. A portion of benefits also should vest if the insured holds the policy for a certain number of years. The number of years should vary with the age of purchase.

Other recommended minimum standards are included in our written statement, such as a minimum level of coverage for home and community-based care, and disclosure standards.

In conclusion, AARP strongly supports the establishment of uniform Federal minimum standards for long-term care insurance, and we believe that H.R. 1325 is a very positive step in the right direction. We would urge you to consider including the additional standards I have described.

We also urge the subcommittee to seriously consider the potential benefits of Federal coordination of long-term care insurance data collection and analysis, which will make it possible to monitor the potential impact on consumers of developments and trends in long-term care insurance.

Thank you again, Mr. Chairman, for the opportunity to present AARP's view on this issue. We look forward to working with you and the Congress to ensure that the long-term care insurance products on the market provide meaningful benefits to America's consumers.

Thank you.

[The statement of Gwendolyn M. Bedford follows:]

STATEMENT OF THE AMERICAN ASSOCIATION OF RETIRED PERSONS

Thank you, Chairman Stark. My name is Gwendolyn Bedford and I am a member of the Board of Directors of the American Association of Retired Persons. On behalf of AARP, I want to thank you for this opportunity to discuss the need for federal regulation of long-term care insurance. AARP strongly supports federal minimum standards for long-term care insurance, and we believe your bill, H.R. 1325, represents an important step toward protecting consumers by assuring more uniform and adequate regulation of this relatively new product.

I will focus my remarks in three areas: the potential of private insurance solutions, the need for a federal role in long-term care insurance regulation, and appropriate minimum standards for policies.

The Potential of Private Insurance

The development of the private long-term care insurance market over the past several years demonstrates that private insurance can help some people, but that its potential for meeting the long-term care need is limited. We believe that it is essential for the federal government to play a much stronger role in financing long term care. Neither private sector initiatives alone nor tax-subsidized efforts by the private sector can solve this problem. Thus, while we should encourage private sector activity that may develop new and innovative mechanisms for delivering and reimbursing such care, there is a need for a comprehensive public long-term care program based on the principles of social insurance and shared risk, similar to H.R. 5393, introduced by Chairman Stark last session. Under such a social insurance system, private sector approaches can and should supplement the public system by covering copayments, deductibles and extra services.

The long-term care insurance market is growing. The Health Insurance Association of America estimates that over 1,000,000 long-term care policies are presently in force, more than double the estimates of only two years ago. Further, over 100 insurers are now offering some type of long-term care insurance coverage.

Several reasons explain this growth. First, and most important, older persons are beginning to understand the financial risks associated with the need for nursing home or home care services. Second, insurers have shown greater interest in this market and have improved the policies available. More recent offerings tend to cover a broader of range of services and contain fewer restrictions.

Although this market will grow, there are a number of reasons why private long-term care insurance will not and cannot be a viable solution for most people to the problem of paying for long-term care needs. Cost and underwriting restrictions severely limit the number of people who can benefit from private insurance. Long-term care insurance premiums tend to be steep -- especially for policies with meaningful benefits which keep pace with inflation. Cost sharing requirements -- deductibles and coinsurance -- are also expensive. For example, assuming a nursing home cost of $80 per day, a 100-day deductible would require an out-of-pocket expenditure of $8,000; if the policy provides an indemnity benefit of $65 per day (about 80% of costs), the insured individual would be responsible for the remaining $15 per day, up to $5,475 per year. These amounts, of course, would increase over time as nursing home costs rise.

In addition, underwriting restrictions eliminate those with potentially disabling medical problems. While this may be necessary to maintain stable premiums, it leaves persons with disabilities without any method to protect themselves from devastating long term care expenses. And for the very aged -- those 75 and over -- coverage restrictions and/or very high premiums usually make insurance purchase unlikely or unwise.

The limited nature of the policies available -- in part caused by insurers' lack of experience -- also limits this market's potential. Even with the improvements of the past several years, the policies on the market today have significant restrictions and exclusions that limit their effectiveness. Many available plans are not indexed for inflation and hence will fail to keep up with the escalating costs of care. Some plans require a substantial deductible. Home and community-based benefits are generally available only after the covered individual has been in a nursing home. Prior hospitalization requirements are still common. Unfortunately, these specific shortcomings have an even greater impact on purchasers because they often fail to understand the significance of these restrictions until after they need care.

Federal Oversight of Long-Term Care Insurance Market

AARP believes that federal oversight of the long-term care insurance industry is necessary. Federal standards could play a valuable role in consumer protection by (1) assuring that long-term care insurance is marketed and sold in a fair and informative manner, (2) eliminating certain limitations and restrictions that cause confusion and reduce the value of policies, and (3) requiring that policies meet certain minimum standards of coverage. The federal standards established in the Baucus Amendment have increased consumer protection and reduced substandard products in the Medigap area. We believe a

federal/state approach not unlike Baucus is important to prevent abuses associated with long-term care insurance and to ensure that consumers in all 50 states have this protection.

AARP also supports federal involvement in long-term care data collection and analysis. Such a national and coordinated data collection system could substantially improve the quality and quantity of information about long-term care service use, the price, distribution and effectiveness of long-term care insurance, as well as its impact on government program expenditures. A comprehensive federal information system would assist states and the federal government in regulating and monitoring this developing market to assure that buyers receive a fair return on their insurance investment.

Minimum Standards.

H.R. 1325, which you introduced Mr. Chairman, establishes a joint federal and state approach to long-term care insurance regulation. The standards proposed in H.R. 1325 build upon the model regulatory standards developed by the National Association of Insurance Commissioners (NAIC), which have been adopted in some form by 26 states over the past three years. Given this state acceptance, we feel that the NAIC model standards are an appropriate basis for a federal and state regulatory approach. AARP state legislative committees have often supported the NAIC model standards as a good starting point for state regulation of long-term care insurance.

H.R. 1325 proposes several significant standards which, when added to the requirements of the NAIC model standards, would increase consumer protection. In particular, AARP strongly supports the provision in H.R. 1325 which prohibits conditioning any benefit on prior receipt of hospital or nursing home care. The requirement that insurers offer buyers the option of purchasing home and community-based benefits also is significant.

AARP also has identified a number of other standards and provisions which we feel are necessary to increase consumer protection and understanding. They are briefly described below:

1. Inflation Protection.

The biggest limitation in many current long-term care insurance policies is their failure to assure meaningful protection over time. Long-term care costs are increasing rapidly, and unless benefits increase as quickly, purchasers will be left with inadequate coverage. For example, the Brookings Institution report, "Caring for the Disabled Elderly" found that if nursing home fees increase

5.8 percent per year, a $50 per day indemnity benefit would have to grow to more than $271 per day to maintain its purchasing power after thirty years.

Insurers should be required to offer insureds an option to increase benefits to reflect increases in long-term care service costs. Insurers should do one or more of the following:

-- provide service benefits (coverage for a predetermined percentage of actual or reasonable costs);

-- provide indemnity benefits which periodically (no less than annually) increase (on a compounded basis) by an identified percentage, or;

-- provide indemnity benefits and periodically offer (at least every three years) insureds the opportunity (without regard to health status) to increase their level of coverage. Insurers should be permitted to charge an additional premium for the benefit increase.

2. Nonforfeiture values.

Long-term care insurance is a combination of risk sharing and saving. Purchasers typically pay premiums for many years and insurers establish and hold reserves over long periods. In most cases, if a purchaser lapses the coverage -- fails to pay premiums -- he or she is left with nothing. This can be very unfair. Often purchasers drop coverage because they no longer can afford it, because of the death of a spouse or a rate increase by the insurer.

In order to prevent this inequity, long-term care insurance policies should have a nonforfeiture provision. At a minimum, policies should vest some portion of benefits if the insurer increases the premium (or otherwise is able to change the terms of coverage). A portion of benefits also should vest if the insured holds the policy for a certain number of years. The number of years should vary with the age of purchase.

3. Minimum Coverage for Home and Community-Based Care.

As discussed above, AARP supports the provision in H.R. 1375 which requires insurers to offer home and community-based benefits in policies. To make this requirement meaningful, however, a minimum level of coverage should be indicated.

We believe that insurers should be required to offer the option of purchasing coverage for home and community-based benefits in long-term care insurance policies. A minimum of 250 home care visits (nurse, therapist or homemaker/home health aide) should be offered. A minimum standard of 250 visits will provide coverage for about one year of services (assuming approximately 20 visits per month for twelve months).

4. Disclosure Standards.

Given the limited nature and complexity of long-term care insurance coverages, it is vital that potential purchasers be well informed about the nature of the risk as well as the benefits offered by the policy. The model outline of coverage developed by the NAIC is a good beginning, but additional information is necessary.

The standards for outlines of coverage should be expanded to include at least the following: information on national average costs for nursing home and home health care; information on the distribution of nursing home lengths of stay; information about the number of functionally impaired elderly who remain in the community; and, information on cost increases in nursing homes, including graphic presentation of projected future costs and projected increases in insurance plan benefits. The form and content of these disclosures should be standardized to the extent possible.

Federal Data Collection.

In addition to establishing minimum standards for long-term care insurance, federal involvement in long-term care data collection and analysis could be extremely important in assuring wide availability of information about this new and developing product. Since this is a very new product, the financial and utilization assumptions supporting the rates are often more the result of speculation than of experience. Competition cannot yet be relied upon to keep prices low; neither buyers nor sellers have sufficient information to assure efficient performance of the market for these products. Federal data collection would greatly help both buyers and sellers by providing necessary information upon which to base and compare prices.

A federal role also would provide needed coordination. Centralized collection and uniform data standards would greatly increase understanding over time about use of services, number of insurance purchasers, availability and affordability of coverage, and administrative costs. The effects of insurance purchase on public programs (primarily Medicaid) also could be studied. While state data collection efforts could ideally achieve the same results, the inevitable problems in achieving uniformity of data standards and data integration would undoubtedly make state efforts less effective.

A comprehensive federal information system also is necessary to provide state and federal authorities with the information they need to assure both that buyers receive a fair return on their insurance investment and that rates are adequate to preserve insurer solvency. Until a broader national system of coverage is developed to address the long-term care needs of all Americans, the government has a responsibility to assure that private coverages perform efficiently and fairly. Unlike most other insurance products, dissatisfied long-term care insurance buyers usually cannot choose another product or company -- changes in the age or health status of purchasers often make switching coverage impractical or impossible.

The specific data elements that should be collected at the national level will be a subject of intense debate, but several types of information should be seriously considered: cost and utilization of services, by type of service; diagnoses (type and extent of functional impairments or physician's assessment) at time of service use; short- and long-term financial results, including yearly (term) allocations for claims, current expenses, amortized acquisition and development expenses, reserves and profits; premiums and premium adjustments; number of purchasers; lapse rates and other information about policy lapses; cancellations; and provider payment arrangements, including reimbursement levels by service.

Conclusion

As the long-term care insurance market expands, increased state and federal regulation will be necessary to protect consumers from substandard products and sales abuse. Experience with the Baucus Amendment in the Medigap area has demonstrated that federal minimum standards can improve consumer protection. AARP strongly supports the establishment of uniform federal minimum standards for long-term care insurance, and we believe that H.R. 1325 is very positive step in the right direction. We would urge you to consider including additional standards in the areas of inflation protection, nonforfeiture benefits, minimum coverage requirements for home and community-based care, and disclosure. We also urge the subcommittee to seriously consider the potential benefits of federal coordination of long-term care insurance data collection and analysis, which will make it possible to monitor the potential impact on consumers of developments and trends in long-term care insurance.

Thank you again, Mr. Chairman, for the opportunity to present AARP's view on this issue. We look forward to working with you and the Congress to ensure that the long-term care insurance products on the market provide meaningful benefits to America's consumers.

Chairman STARK. Thank you.

I would like Gail or Josh to take a shot at this. I'm not convinced—and I think some insurance companies share this—that this is really an insurable risk. Second, if it is insurable, that we have anywhere near enough accurate data to get any kind of actuarial agreement as to how it ought to be funded. If you've got a 50-percent payout with basically all of the relief valves operating on the side of the insurance company, the ability to raise rates to cover bad assumptions early on, and no protection against inflation, which one presumes is a risk that is borne entirely then by the insured, if there are any risks in these policies, they're borne by the insured. Basically, you have just a high, front-end loaded savings plan. One thing they know is half the people will die before they need the benefit. They don't give them any of their reserves back. Another half of that half who survive will need care for less than a year because they'll die.

So the only risk factor out there is the 25 percent who may go beyond a year, and they're not sure of that. And if the experience gets too bad, they can kick the rates up.

It seems like it's a "lose-lose" deal for the insured and a "win-win" for the companies.

Gail, how do you feel about that? Should we do it at all? The first question is should we allow this stuff to be sold—Is it any good for people?

Ms. SHEARER. I think that you're making a very good point. Years ago, the insurance industry concluded that it was not an insurable event and they steered away from this market. Now we're at the point where individual insurance companies have decided that it is an insurable event because, as you say, they have structured it so that the risk is basically not on their shoulders.

From a public policy point of view, I don't think that the private long-term care insurance solution is going to help us with long-term care for the majority of people. As Brookings has pointed out, even a relatively modest policy will be affordable by only 25 percent of people, and they're the most well off. Anybody with moderate or lower income is going to be left out of the system.

I didn't get into this in my statement, but we really believe that the solution to long-term care is primarily in the public domain. The private market will help some people—a small percent of the elderly, largely relatively well-off people. As policies continue to improve—as restrictions are eliminated—the private market will be more effective in helping these policyholders. But we should not kid ourselves into thinking that we've solving the long-term care problem.

Chairman STARK. Let me follow on that in just a minute, and then I want to hear from Josh.

Wouldn't you agree that, whether you take the money value of man or whatever an insurable interest is, in the most technical sense, that if $25,000 a year is the maximum exposure based on the idea that this, at current dollar cost, is what you could be in a nursing home for—so you've got $25,000 a year, you get 21 "squares" a week, clean sheets and care, regulated by some State—and if you need that, you don't need anything else, haircuts and things that SSI might provide, but basically—now, if you've got

that, if you're a Congressman, you're going to get your congressional retirement, you don't need long-term care. Anything else that you're buying is either asset protection or buying frills. You could sort of set an upper limit and it's strictly an income question.

What would you say to the proposition that anyone who will receive enough retirement income to pay the nursing home care minimum, basically doesn't need this insurance for long-term care? They may need it, as I say, for asset protection or whatever else.

Ms. SHEARER. Well, it's complicated, because when spouse are involved——

Chairman STARK. Let's uncomplicate it by just saying that everyone is a single person in this world and we all take care of ourselves. My spouse isn't going to take care of me and I'm not going to take care of her, one of those sorts of things. Let's just leave that for a minute.

Let's just say as an individual, a piece at a time—that's what I said. Anything beyond the $25,000 is asset protection. You protect assets for your spouses, for your grandchildren or your charitable foundations.

Ms. SHEARER. A lot of people do go into a nursing home and then come out again——

Chairman STARK. But then their income is still there.

Ms. SHEARER. Well, many do spend down their assets rapidly in a nursing home.

Chairman STARK. Why should they have to if their income covers the nursing home costs?

Ms. SHEARER. Well, the percent of people who fall into that category of having high incomes is pretty low.

Chairman STARK. Let me go back. I'm just saying that anyone who has a retirement income that is guaranteed for the individual sufficient enough to pay the nursing home costs but, by definition, doesn't need long-term care insurance for that purpose. They may need some kind of other financial insurance for other purposes.

Mr. WIENER. May I respond to that?

Chairman STARK. Yes, go ahead.

Mr. WIENER. I think you're basically right, so long as we're talking about today. The problem that I think we face revolves around the inflation issue. If you're 65 and you've got a $25,000 pension, if you go into a nursing home tomorrow, you're great. You don't need any——

Chairman STARK. We're still talking about an income policy for retirement. Should retirement be indexed to inflation? Let's assume for a minute it is.

Mr. WIENER. OK. But since nursing home and home care inflation is likely to be more than the pension is increased, then when you hit 85, that $25,000 is probably more like $75,000——

Chairman STARK. Let me fix the inflation protection in there. Let's assume, instead of fussing with this today, we just wave our wand. Before all my colleagues came, I could have done it by unanimous consent. [Laughter.] We say we will make Social Security's minimum payment, that which will allow anybody to stay in a nursing home. We don't need long-term care insurance any more, do we?

Mr. WIENER. Well, that's right, except that the number of elderly with incomes over $25,000, especially on an individual basis, since you've done away with marriage [laughter] it's not very large a number.

Chairman STARK. No, I just said we would change that. The minimum Social Security benefit will become, from this day on.

Mr. WIENER. If you can pay for it out of your current income, then you certainly don't need anything else.

Chairman STARK. Then going back, should we be allowing long-term care insurance to be sold today? Is there a social benefit for doing that, or are there other means of savings and acquiring assets that would probably be better suited?

Mr. WIENER. I don't think that there are mechanisms, other kinds of risk sharing solutions, currently available. As you know, Alice Rivlin and I believe that we ultimately need some sort of public insurance to cover at least part of the cost of long-term care because we don't believe that private insurance will reach far enough down the income distribution and will cover enough.

I think the basic idea of risk-spreading makes sense in long-term care. As you noted, most people will not end up having extensive nursing home stays.

In responding to your second question, while one could wave your hand and end up with everyone getting a retirement income of $25,000, in fact, we don't have that situation today. Many people do not.

I think that asset protection is one reason that people buy private insurance, but it is not the only one. People also buy private insurance because they want a greater choice of where they go for nursing home care, and a greater choice on what kind of services they get. They buy insurance to try to keep from being a burden on their children. The kids are never quite as bad as you make them out to be.

People also buy insurance to try to stay off welfare. We have a large number of people who have worked hard all their life and the last thing they want to do is end up on Medicaid as they decline in their final days. So there are a variety of reasons why people buy insurance. Asset protection is the major one, but not the only one.

Going back to your first question, I think what's really interesting about the whole question of insurable risk and the entry of private insurance companies into the market is that it was really kind of a gestalt change. There was not a whole lot of new data that was brought to bear. There certainly hasn't been a whole lot of experience, at least in terms of paying claims, that would lead the insurance companies to change their mind. But there's no doubt that they have, and there are 105 companies selling policies, including all of the major ones. They may have had to have beaten the actuaries up around the ears, but they have signed on. I think they are at this point committed to the idea that long-term care is an insurable risk.

Chairman STARK. What do you think? Is it not an insurable risk?

Mr. WIENER. I think it's an insurable risk. I think there is presently a lot of uncertainty about it. I think, in order to make policies better and adequate, the companies are going to have to assume a great deal more uncertainty. I think that's going to be

necessary, and it is going to increase premiums and it's going to make policies less affordable. For example, a policy that does not index for inflation I think is a highly inadequate policy, and one that severely misleads people who buy it.

Chairman STARK. Isn't there a matrix that you people who count beans for a living could give us at which point a savings account really is a better gamble? In other words, if your universe is at 65—and I was just looking at your article on Hancock's policy—in very round figures is $1,000 a year and it pays $100 a day for up to 7 years. But you figure that out of that population half won't ever use it, and of the half who do use it or might use it, many will die, and 25 percent of the population will only use it for less than a year. So the exposure there is less than $35,000. At some level you could say "wait a minute". If you knew, or you could sort it out, it's just a very, very poor savings policy.

Where do you cross the line?

Mr. WIENER. In our book we look at saving strategies, particularly individual medical accounts, and we didn't find that they worked very well. In fact, they worked considerably less well than the insurance strategy we looked at.

I think the basic fact of the matter is that Americans are not savers. They do like to buy insurance, though. I think that's the key, combined with the idea of spreading the risk.

You have got to save an awful lot of money to pay for 5 years or 6 years worth of nursing home care, especially given the fact that nursing home and home care inflation is likely to be substantially greater than the CPI, which in turn substantially erodes your interest earnings.

Chairman STARK. What if you go this route. It was the insurance commissioners of "yore" who created cash value, and therefore the heartburn that we have in trying to figure out how to tax life insurance. The reason that cash value ever came into being was certainly not the generosity of the insurance companies, because when they started peddling life insurance, they kept it all. You didn't get any money back if you canceled your insurance, even though they had originally in the first level premium.

I think what you're suggesting is the same thing here. There may be tremendous over reserving, or a tremendous amount of reserve in each individual policy, and pretty soon the public is going to want, if they let the policy lapse, or if they elect not to renew it at a kicked up premium, some of the reserves back. The minute you do that, the only way your system works is with a group policy. Because if you're really selling a policy on an individual actuarial table and the person has the right to draw out their reserves, the whole thing gets more expensive.

Mr. WIENER. It gets more expensive, but I think that's the price of the game.

Chairman STARK. So you don't have to be group to work?

Mr. WIENER. You certainly are not going to be able to get 35-year-olds to pay in at large numbers unless they've got some chance of getting their money back. I don't see any other option in that area.

Chairman STARK. Does the gentlelady from Connecticut wish to inquire?

Mrs. JOHNSON. Thank you, Mr. Chairman.

I am interested, Miss Shearer, in your comments regarding at-home care. In Connecticut, we have had enormous success with preventing institutionalization of our elderly by developing rather precise criteria as to when a person can no longer be supported at home and needs to be in a nursing home.

I certainly believe that this kind of incentive is very important, both in containing costs and to preserving quality of life for our elderly. I believe that if we do anything in regard to proposing some Government view of long-term care policies, that that Government view ought to encourage long-term, at-home care.

Why do you recommend limiting the basic policy to nursing home care?

Ms. SHEARER. I'm a little puzzled because I didn't know that I said that.

Mrs. JOHNSON. That's the way I heard it, from your comments.

Ms. SHEARER. No. I would not limit policies to nursing home care. As a matter of fact, the trend certainly is for these private policies to include home care in them. I'm not sure where the confusion is, but I certainly did not intend to say that.

Mrs. JOHNSON. Good.

Thank you, Mr. Chairman.

Mr. LEVIN [presiding]. Mr. Chandler.

Mr. CHANDLER. I would just like to make a very brief comment.

I think we are really trying to shoot at a moving target. I'm sorry that the chairman isn't here, because while I certainly respect his efforts, I think we all fully understand what we're dealing with here would be terribly inaccurate.

When we added the catastrophic health insurance bill last year, I think there was, among Members of Congress and the elderly, a great deal of confusion about what is left in the way of risk after the passage of this legislation, both in terms of traditional medigap policy and also the long-term-care policy.

I think we need to move very carefully. While all of you are saying that we ought to factor inflation into the policies, the obvious question is, how do you pay for it and who pays for it. How do you expect an insurance company to know what that inflation is going to be in the future. So before we take these kinds of steps, I think we have got to be very cautious.

The second area of caution that I personally would advise is that we not try to make too many decisions for people who are perfectly capable of making decisions for themselves. On the one hand I think that there is certainly good reason, obviously good reason, to be very cautious about protecting the elderly, because many times they are victimized by the unscrupulous. We all know that. There is evidence that that existed in the medigap insurance area; it probably still does, and I think it is beginning to show its ugly head here.

At the same time, I don't want to see legislation passed that is going to end up removing from people the opportunity to make their own choices about what they want for their own family security.

Let me make a final point concerning legislation that I am working on, along with the assistance of many others on this committee,

which is for the employer provided prefunding of both retiree medical benefits and long-term health care plans. The legislation is scheduled for hearings in the Oversight Subcommittee in early June and would allow the opportunity for prefunding of this very kind of health care plan.

So I think we both have to look on the side of protecting the individuals from the unscrupulous—clearly, that's always a problem in any society—but also we have to look for the resources to provide these benefits in the future, aiming at the idea of creating savings that will be there for people. That's the reason we have introduced this legislation—to allow for this prefunding.

Thank you, Mr. Chairman.

Mr. LEVIN. Thank you very much.

I'm sorry I missed the earlier testimony and have just heard the colloquy, so let me just ask the three of you: Looking into the crystal ball just a bit in this field, how far do you think we can go with a system of private insurance and public regulation versus a more comprehensive approach to long-term care? That strikes me as an issue that we need to face as soon as we can, and I think you have touched on that. But where do each of you come down on that?

Mr. WIENER. Well, the simulations that we have done at the Brookings Institution suggest that, with some quite optimistic assumptions, maybe somewhere over the next 30 years, we would wake up and we would have maybe somewhere between 25 and 45 percent of the elderly with private insurance, but that that would probably pay for only about 7 to 12 percent of nursing home expenditures and would have a fairly small impact, maybe 1 to 5 percent, on the number of Medicaid nursing home patients and on Medicaid expenditures.

I think my summary judgment would be that clearly the private insurance market can do a lot more than it's doing now, but I don't think we should think it's a panacea because it's not. I think ultimately we're going to have to have an expansion of public programs to take care of the broad, overwhelming majority of elderly.

Ms. SHEARER. If I might just comment on that, I think it is important to keep in mind who is left out of the system if we have just private long term care insurance. First of all, it's the young. Children who are born with major problems requiring home or hospital care over the long term, there is no way that they are part of this market.

Also left out are people 65 or over, or 60 or over, or really virtually any age, who have health risks that keep them from qualifying for a policy.

Finally, as Dr. Wiener points out, people who can't afford policies are left out.

It is because of these reasons, and many others, that Consumers Union feels that the solution has to lie at the social insurance type of level. We are not optimistic that private long-term care insurance is going to solve a substantial part of this problem.

Ms. BEDFORD. I would like to also comment, Mr. Chairman.

Our position definitely is that private insurance must be a supplement to a social insurance program. For instance, I cannot possibly afford this insurance in any shape, form, or manner. There is

no way I can possibly cover it, because I've only got 2 years and I'll be 80. My pension pattern does not accommodate this.

So those of us that are in my position—in other words, lower-middle-class people—what we're looking at at the present time is, if nothing is done about it, is the spenddown in Medicaid.

Mr. LEVIN. Well, this hearing in part, is to debate this very issue. It seems to me that we have to—this is my experience working within the family, my own family, to begin to think this thing through, because otherwise, we're in a "catch 22" situation. If the private sector can, indeed, meet a considerable portion of the need here, heavily regulating it is going to work against doing that, arguably, anyway.

Mr. WIENER. I guess I wouldn't agree with that. It seems to me that the only way it's going to be useful is if, in fact, the policies provide substantial benefits. That, I think, will ultimately require some combination of regulation, either at the State level or the Federal level, and market pressures by consumers to make it that way.

We have gotten too enamored with counting the number of people with policies. The real question is what do those policies cover and what is the likelihood that people who end up needing those services actually get some benefits.

Mr. LEVIN. All right. Well, this is not the beginning but is far from the end of the discussions. So let's call this panel's presentation to a close. Thank you very, very much.

Our next witness is Mr. Pomeroy. Mr. Pomeroy is the vice president of the National Association of Insurance Commissioners and is the insurance commissioner for the State of North Dakota.

Talking about a moving target, we regret that we'll be the moving target for the next 10 or 15 minutes. Why don't you begin, and when Mr. Stark, the chairman, returns, I will leave.

We welcome you, Mr. Pomeroy.

STATEMENT OF EARL R. POMEROY, VICE PRESIDENT, NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS, AND INSURANCE COMMISSIONER, STATE OF NORTH DAKOTA

Mr. POMEROY. Thank you, Mr. Chairman. I am very pleased to be here.

My name is Earl Pomeroy. I am commissioner of insurance from the State of North Dakota. I am also vice president for the National Association of Insurance Commissioners, and I am appearing on their behalf this morning. I also serve as chairman of the committee dealing with developing regulatory standards for long-term care insurance and will speak in that capacity also.

We certainly appreciate the concern which has led to the introduction of H.R. 1325. We share the consumer protection concerns which have been voiced by the very, very capable individuals on the preceding panel. The core of what we see our responsibilities as State insurance regulators is consumer protection.

In my presentation this morning I will give a brief overview of how we have approached this rapidly developing marketplace, detail components of our present regulatory standards, outline issues that we are presently reviewing, and give you our position,

at least at the present time, relative to H.R. 1325. In the conclusion, I will identify an area where we think additional Federal activity may be very appropriate, and that is in developing further criminal sanctions for marketplace abuses that are occurring in this area.

First of all, let me briefly tell you about the NAIC's approach to this issue. We recognize that long-term care insurance was a product beginning to move. In 1984, we specifically charged a committee to study this market. We studied it throughout 1985 and developed regulatory standards in 1986.

We recognized at that time that, unlike a number of insurance products, where our sole concern was consumer protection, in this instance there was a public policy purpose served by the development of this marketplace; that is, we felt, both based in a macroeconomic and microeconomic considerations.

On the macro level, we wanted additional private financing of long-term care insurance. Although our job is regulating insurance, we recognized the burden States are carrying with their present Medicaid budgets and hoped that this would offset some of their obligations in that area.

On the micro level, an area we have become increasingly sensitive to, we recognized that individuals want protection from the ruinous costs of long-term care. In a rural State such as North Dakota, oftentimes the ability of a family to pass on the family farm, for example, is at stake, in terms of whether they can protect the parents from long-term care expenditures. So we have sought to regulate the product in a very meaningful way, but not stifle it or extinguish it before we have really seen what potential private long-term care insurance can reach.

The NAIC Long-Term Care Insurance Model Act, which is presently adopted in 26 States and pending in 10 others, and the model regulation, adopted in 9 States and pending in 8 others, affords certain protections to the consumers:

First, no product can be marketed or advertised as long-term care insurance unless it meets the requirements of the model.

The benefit period must be at least 1 year, and policies may not be individually cancelled due to advancing age or deteriorating health, and coverage for preexisting condition is limited to 6 months.

The insured as a 10-day free look, if sold on an individual basis, and 30 days if a mass marketing solicitation, and long-term care insurance may not exclude coverage for Alzheimer' disease.

Long-term care policies may not limit coverage to skilled nursing home care, nor provide significantly more coverage for skilled care in a facility than coverage for lower levels of care, and the loss ratios must be at least 60 percent.

The "moving target" as was mentioned by Representative Chandler, I just can't emphasize how fast this product and marketplace have developed, even in the past 3 years.

We have sought to keep pace, as insurance regulators, and the more we've learned about the market, the tougher we have made our minimum regulatory standards. In 1988 we amended the model to prohibit conditioning any long-term care benefit on a prior hospital stay; we prohibited products marketed as "home health care"

or "home care" from conditioning the receipt of benefits on a prior hospitalization stay.

We prohibit the conditioning of eligibility for benefits provided in an institutional care setting on the receipt of a higher level of institutional care—for example, requiring skilled care before receipt of custodial care.

We require a detailed and uniform outline of benefits to facilitate consumer shopping in this complex market, and we require group long-term care insurance products to provide for continuation or conversion at extinguished employment.

Our work in this area of keeping appropriate regulatory standards in place is far from over. We are continuing to address many significant issues and suspect that we will take action within 2 weeks at the June meeting in the following areas:

Prohibiting and addressing the insidious practice of "post claims" underwriting; establishing reserving requirements for life policies containing long-term care benefits; developing a disclosure form for residential facilities providing personal care and health care services, including long-term care, to people of retirement age, the continuing care retirement communities.

We will be developing a proposal on inflation protection, and preparing a consumer guide for long-term care insurance.

By the end of this year, I anticipate that we will develop a reporting form for CCRC data, develop a reporting form for loss ratio experience, explore guaranty fund coverage for long-term care policies in the event of an insurance company insolvency, examine the propriety of returning cash to consumers who have paid long-term care premiums but who have not collected—the nonforfeiture issue discussed earlier—and develop specific protections for home health care benefits.

In light of this activity, we oppose H.R. 1325 because we believe a Baucus-like approach is not necessary or appropriate at this time. Although H.R. 1325 is patterned after the Baucus amendment, it differs in two important respects:

First, it does not designate all of the NAIC standards as the standards necessary for certification. H.R. 1325 picks and chooses between NAIC model and additional new requirements for certification. The result is a very confusing piece of legislation that we think takes a piecemeal approach to regulating this marketplace, rather than the thorough, technically studied approach taken by the NAIC.

Second, the long-term care insurance market is very different from the Medicare supplement market. It does not lend itself to singular regulatory treatment at this time. We are clearly talking about a moving target and regulatory standards need to continue evolving.

Further, as written, H.R. 1325 would eliminate the States' authority to promulgate regulations. This is a significant drawback to effective regulation of the rapidly changing long-term care insurance product.

For these reasons, we oppose.

We also think that within a very short period of time there will be adopted, on a State-by-State basis, a comprehensive framework of regulatory protections. We will acknowledge this morning that

within 2 years from the date of this hearing, in the event there are significant pockets of the country unprotected by the NAIC model or similar regulatory response, our reservations to a Federal action would be somewhat reduced.

There is, however, an important role for the Federal Government in the long-term care insurance market and in insurance products sold to senior citizens. While it is the States' responsibility to regulate the marketplace, there is certainly room for criminal prosecution of some of the more egregious market conduct activities that we have witnessed, primarily occurring at the agent level.

Last week, for example, in North Dakota, despite a valiant effort by the U.S. attorney, an agent whom we had revoked—we had revoked his license, but in my opinion, his conduct warranted time in a Federal penitentiary—was unsuccessful in proving the case, in light of basically a minimal criminal prohibition on his activity. I think if the Federal Government wants to look at cleaning up the market, they ought to look at improving criminal sanctions.

In conclusion, Mr. Chairman, I would assert that the NAIC has moved aggressively to develop a State regulatory framework for long-term care insurance. We think the framework will soon be in place in all of the States. The NAIC will continue to monitor the long-term care insurance marketplace. We are committed to addressing the outstanding issues in this area, including inflation protection, nonforfeiture benefits, level commissions, CCRC's, life riders, and reporting formats.

We believe that we have the expertise to devote to these issues. We agree with you, Mr. Chairman, that finding ways to pay for long-term care insurance is a serious concern, but establishing a Federal regulatory oversight system will not, at this time, in our opinion, address that problem. This concludes my prepared remarks. I will be happy to answer any questions.

[The statement of Earl R. Pomeroy follows:]

STATEMENT OF THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

As Vice President of the National Association of Insurance Commissioners (NAIC) and Insurance Commissioner of the State of North Dakota, it is a pleasure to address the Health Subcommittee of the Committee on Ways and Means. The NAIC is a non-profit association consisting of the 50 insurance commissioners from the states, the District of Columbia and the territories of the United States. We appreciate this opportunity to comment on H.R. 1325 which would establish federal standards for long-term care insurance.

The purpose of this testimony is to briefly discuss the development of the NAIC model act and regulation, to review your draft bill and to explain why the NAIC opposes the bill at this time.

DEVELOPMENT OF THE MODEL ACT AND REGULATION

Long-term care insurance has developed rapidly as a significant insurance coverage marketed primarily to senior citizens for the purpose of covering the cost of long-term care for chronic health conditions. The number of companies offering this coverage and the variety of policies available has increased dramatically in the last few years. There are now over 100 companies offering long-term care insurance. The growth of this

particular insurance marketplace is viewed by regulators as positive development for a number of reasons.

First, there is a great deal of consumer interest in having a high quality nursing home insurance product available. Consumers are otherwise faced with depleting their assets to cover long-term care costs. Undoubtedly, these individuals would prefer to protect themselves and their assets through the purchase of a long-term care policy.

Second, it is believed that the demand for long-term care products would be stronger if consumers were fully informed about their exposure for long-term care costs--costs which are often thought to be covered by Medicare or other sources.

Third, there is a substantial government budgetary interest in long-term care insurance. It is my understanding that federal and state governments finance over 40 percent of all nursing home expenditures through the Medicare program. Faced with demographic projections of an aging population, there is a vital public urgency in injecting additional amounts of private dollars into the present financing picture.

These strong consumer and public interests favoring increased availability are accompanied by a recognition by state insurance commissioners that certain protections must be afforded

the consumer, particularly in the initial development stages of the product. These interests led the NAIC to focus its attention on developing a model act and subsequently a regulation, both designed to:

> ...promote the public interest, to promote the availability of long-term care insurance policies, to protect applicants for long-term care insurance...from unfair or deceptive enrollment practices, to establish standards for long-term care insurance, to facilitate public understanding and comparison of long-term care insurance policies, and to facilitate flexibility and innovation in the development of long-term care insurance coverage. Long-Term Care Insurance Model Act, Model Laws, Regulations and Guidelines, Vol. I, No. 132.

The NAIC Long-Term Care Insurance Model Act (adopted in 26 states and pending in 10 states) and the Model Regulation (adopted in 9 states and pending in 8 states) afford certain protections to the consumer:

1. No product may be marketed or advertised as long- term care insurance or nursing home insurance unless it meets the requirements of the model.

2. The benefit period must be a least one year in duration.

3. Policies may not be individually cancelled due to advancing age of the insured and may only be cancelled as a class with the commissioner's approval (upon a

showing that the book of business threatens dire economic consequences to the company and the losses cannot be stabilized).

4. Coverage for preexisting conditions of the insured may only be limited to a period of six months from the inception date of the policy.

5. The insured may return the policy for a full refund within the first ten days after the policy has been delivered, or within thirty days after delivery if the policy was solicited directly, that is other than through an agent (e.g., direct mail or television ads).

6. Long-term care insurance policies may not exclude coverage for Alzheimer's disease.

7. Long-term care policies may not limit coverage to skilled nursing care nor provide significantly more coverage for skilled care in a facility than coverage for lower levels of care.

8. Loss ratios must be at least 60 percent.

Significant consumer protection mechanisms were added to the models in 1988:

1. The conditioning of any long-term care benefit on a prior hospital stay is prohibited (effective one year after adoption of this amendment).

2. Products marketed as "home health care" or "home care" cannot condition receipt of benefits on a prior hospitalization or prior institutionalization requirement.

3. Conditioning eligibility for benefits provided in an institutional care setting on the receipt of a higher level of institutional care ("step-down") is prohibited.

4. A detailed outline of coverage must be delivered to all prospective applicants for long-term care insurance at the time of initial solicitation.

5. Group long-term care insurance must provide for continuation or conversion of coverage.

These revisions reflect input which the NAIC and the states solicited from consumer organizations and members of the insurance industry.

CURRENT NAIC ACTIVITY

The NAIC is closely monitoring the long-term care insurance marketplace. As a result, the NAIC has revised its models annually to reflect changes in this developing marketplace. At the present time the NAIC is continuing its dialogue with the industry and consumer representatives of seniors and has recently held a discussion with various researchers in the long-term care insurance field to exchange ideas on whether mandating two years of coverage is in the best interest of the consumer in light of the average length of nursing home stays and the ability or inability of individuals to afford long-term care coverage.

For some time, the NAIC has been addressing many significant mechanisms which we believe will further protect the senior citizens of this country. At the June meeting, the NAIC intends to:

1. Prohibit the practice of "post-claims" underwriting;

2. Establish reserving requirements for life insurance policies containing long-term care benefits;,

3. Develop a disclosure form for residential facilities providing personal care and health care services (including long-term care) to people of retirement age

(these facilities are referred to as continuing care retirement communities (CCRCs);

4. Develop a proposal on inflation protection; and

5. Prepare a consumer guide for long-term care insurance.

By the end of the year, the NAIC will:

1. Develop a reporting form for CCRC data;

2. Develop a reporting form for loss ratio experience;

3. Explore guaranty fund coverage for long-term care policies;

4. Examine the propriety of returning cash to consumers who have paid long-term care premiums but who have not collected benefits after a period of time (nonforfeiture benefits); and

5. Develop specific protections for home health care benefits.

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H.R. 1325

The NAIC opposes H.R. 1325 because we believe a federal "Baucus-like" approach is not necessary at this time. Although H.R. 1325 is patterned after the Baucus amendment, it differs in one significant respect: it does not designate all of the NAIC standards as "the standards" necessary for certification. H.R. 1325 therefore is a piecemeal approach to regulating long-term care insurance. The difficulty with the approach is that it is confusing.

Furthermore, by not referencing the states' authority for rulemaking in this bill, H.R. 1325 eliminates the states' authority to promulgate regulations. This is a significant drawback to effective regulation of the long-term care insurance product.

H.R. 1325 also eliminates the discretionary powers of the commissioner which were carefully established by the NAIC to accommodate specific and innovative long-term care products which are shown to be in the public's best interest.

The NAIC cannot oppose, however, the establishment of stringent federal criminal sanctions against unscrupulous conduct imposed upon purchasers of long-term care insurance. We share your concern over the criminal conduct which unfortunately

occurs. We agree that stiff criminal penalties should be imposed to assist federal prosecutors, with whom we work.

CONCLUSION

The NAIC has moved aggressively to develop a state regulatory framework for long-term care insurance. We believe that the framework will be in place soon in all the states. The NAIC will continue to monitor the long-term care insurance marketplace. We are committed to addressing outstanding issues in this area, including inflation protection, nonforfeiture benefits, level commissions, CCRCs, life riders and reporting formats. We believe that we have the expertise to devote to these issues. We agree with you, Mr. Chairman, that finding ways to pay for long-term care insurance is a serious concern, but establishing a federal regulatory oversight system will not address that problem.

Mr. Chairman, this concludes my prepared remarks. If you or any other members of this committee have any questions, I would be happy to address them. Thank you.

Chairman STARK. I apologize, Mr. Pomeroy, for being absent during your testimony. In an attempt to keep the hearing moving along, my colleagues who did hear it are now voting.

I gather that you suggested there might be some areas in which the Federal Government would be of assistance. Could you outline those for me again?

Mr. POMEROY. It involves an area of agent conduct that we think goes beyond an administrative violation but is actually criminal conduct, the exploitation of senior insurance consumers, which is unconscionable, reprehensible, and we think it ought to be dealt with as a criminal violation that goes beyond the authority of insurance regulators.

We can take their licenses, but sometimes we think that greater sanctions are appropriate.

Chairman STARK. A little vacation at public expense could have a very meritorious effect.

Mr. POMEROY. That's correct.

Chairman STARK. Do you have that more specifically? Because this is one of the areas that looks to me like a loophole. You can't sell the insurance by mail. What's an unregulated State? Where does a lot of this stuff leak out of?

Mr. POMEROY. We think that the concern relative to mass marketing is not appropriately attuned to the long-term care marketplace.

Chairman STARK. It could be anything.

Mr. POMEROY. OK. In the long-term care model, we have addressed that. A product can come into the State through an out-of-State group mechanism only if that State has a similar regulatory format—the model statute. So we think we have nailed that loophole shut relative to an out-of-State group marketing the exploitation of long-term care products.

Chairman STARK. But you can't stop the lead cards, right?

Mr. POMEROY. There is some difference of opinion between regulators on that. We have, in our opinion, stopped them in North Dakota. We have authority to regulate insurance. If we can't get a noninsurer using some lead cards, we can certainly get at the insurer purchasing that information from that other entity. So I think that regulators do have authority to address lead cards.

Chairman STARK. You suggested that you're going to take action on the postclaims underwriting. What did you have in mind there?

Mr. POMEROY. Well, we are studying a variety of approaches. Post-claim underwriting is the phenomenon whereby the insurer makes only a tacit effort at eliciting full underwriting data at the time of issuing the application and then denying the claim when the claim comes in on the basis of nondisclosed medical information.

We have seen only incidental exploitation of this product. Of the 100-plus companies marketing these policies, it has turned up as a practice in a handful of companies. One of them, Providers Fidelity, has been dealt with very seriously in my State and is under investigation in other States for rather flagrant abuses of this practice.

In North Dakota we have shortened the period of time for contesting a policy, from 2 years to 6 months, to allow contesting only

after 6 months if they can affirmatively prove misrepresentation by the applicant.

There are other ways to address this issue. The committee that I chair is exploring those presently. We see it as an issue that may potentially be emerging and we're going to take a final action in June.

Chairman STARK. Don't you, as a regulator—and you may not agree that this is yet insurance, but let's assume that it's certainly an area of some of the least accurate actuarial projections—don't you, therefore, have a conflict with the consumer to this extent?

It would seem to me that where we've been in conflict with your group, is on taxation. Your interest is the highest reserves possible because you want to protect the integrity of the assets of the insured; we want to get income tax out of them so we don't really want them to be able to reserve as much out of the premiums. I mean, that's a friendly conflict.

Don't you also, though, have that concern with these newer policies? To be a good regulator and to be cautious, as you should, don't you have to get the companies to build bigger reserves, thereby limiting what policyholders may pull out in terms of cash value, if that's a good analogy? How do you wrestle with that one? Are you concerned that if they over reserve you have to face the question of whether there should be a cash value, a returnable, refundable reserve in these policies?

Mr. POMEROY. Those issues emerge and change somewhat as the market changes. The market we have geared our initial set of regulations at was at the individually sold product to the senior citizen. A 70-year-old purchasing the policy isn't looking for return of premium when they let the policy lapse. They want an affordable policy to protect for long-term care expenses. That's where we've really addressed our regulatory thrust.

As the marketplace grows, and as the younger ages begin to become interested and purchase this product, nonforfeiture becomes a much more pressing regulatory issue.

At every juncture, we have faced issues that are both technical and have public policy ramifications. At what point does consumer protection begin to deprive people of effective access to this product? Where should the public policy line be drawn? We have tried to steer a middle course and I think we have steered a middle course. Certainly some of the actions we have taken will already have driven up the premium for these policies, but one thing drives our consideration—we want every policy sold to offer meaningful benefit coverages, not just the illusion of long-term care insurance, but the reality.

Chairman STARK. Let's try that one for a minute. Do you also regulate securities in your State?

Mr. POMEROY. No.

Chairman STARK. Are you familiar with your securities regulations?

Mr. POMEROY. My brother is securities commissioner, yes. [Laughter.]

Chairman STARK. I presume that you have exemptions for private placements that are similar to many other States, where the person has to stipulate or prove that they have a certain amount of

net worth and a certain amount of sophistication, making risky investments, and that they have enough income to survive the hardships if the risky investment turns out to be a loser? You must have a format for——

Mr. POMEROY. We have some special treatment for private placements. We won't go down the securities regulation line very far, though, before I'm quickly out of any technical——

Chairman STARK. But you have that style of——

Mr. POMEROY. Yes.

Chairman STARK. What about doing that sort of thing in insurance? It costs $80 a day minimum in your State to stay in a long-term care institution?

Mr. POMEROY. No; the average is about 60.

Chairman STARK. Let's assume that somebody buys a policy for $30 a day and they have no other income. They're an SSI beneficiary. You could say that's not going to buy coverage for long-term care.

From your standpoint as a regulator, could you say the agent would have to substantiate that the person could take the policy and put it together with something else to be of any use at all?

Mr. POMEROY. I think that's appropriate. We have developed a regulation which allows us to address both MediGap abuses and long-term care insurance marketing abuses. It's a suitability requirement. The agent has to sell coverage which is suitable to the individual's financial needs. I think that's an important regulatory tool. I would suggest that if there was someone of very limited means that was sold a $30 a day policy, that would be an actionable offense in North Dakota.

Chairman STARK. And that actionable offense could lead to——

Mr. POMEROY. Revocation of license.

Chairman STARK. It can't get any tougher than that.

Mr. POMEROY. A fine, and revocation of license.

Chairman STARK. Is it tough to enforce?

Mr. POMEROY. It is not too tough to enforce.

Now, the agent concern is that it's a very subjective thing and brings subjectivity into the regulatory overlay.

Chairman STARK. But that doesn't scare you. That's what I'm getting at. Do you think other insurance commissioners share your feeling, that you can tread into those subjective waters and——

Mr. POMEROY. The suitability regulation has only been attempted in Minnesota and North Dakota. But based on the way it has worked in my State, I will be urging its broader adoption.

Chairman STARK. You'll know where it will go—Wisconsin, Massachusetts, and where it will never see the light of day, Arizona, Texas.

Mr. POMEROY. Well, North Dakota isn't often lumped in with the regulatory climate of Massachusetts, Wisconsin, and Minnesota. We represent a rural State with a fairly conservative regulatory tradition. I think it indicates that regulators are genuinely concerned about the senior market and are prepared to be more active in their oversight.

Chairman STARK. Do you see the day—and I ask this question for Chairman John Dingell—that the Federal Government will just eventually be involved in regulating part of the insurance industry,

and under what circumstances would that come to pass, if ever, in your opinion?

Mr. POMEROY. Mr. Chairman, I think if States fail to demonstrate that, acting at a State level, we can provide a comprehensive framework of insurance regulations to virtually the entire population of this country, Federal regulation becomes more appropriate. We are committed at the NAIC level to making certain there is a comprehensive network, not just models that are enacted but never adopted. We are committed to making certain that every citizen in the country, through State insurance departments, receive meaningful consumer protection.

Chairman STARK. How many States have signed up to your model code now?

Mr. POMEROY. In excess of—half of them, to date.

Chairman STARK. What if we just passed your model code and said that any State that has it is not subject to the Federal Government and those States that don't, are? Does that do anything for the good States, if that's what we call them?

Mr. POMEROY. I don't think that approach is appropriate at this time, because the States are moving rapidly to bring this on line.

I mentioned, I believe before you came into the room, in the event that in 2 years we're still looking at major chunks of the country that have failed to enact meaningful protections, I believe we will not have much resistance.

Chairman STARK. What is the law now if a loosely regulated State sells a policy by mail in your State? Is there anything you can do to regulate that?

Mr. POMEROY. Yes. We have passed the Long-Term Care Model Act——

Chairman STARK. For any kind of insurance? What's the least-regulated State in the country?

Mr. POMEROY. Oh, jurisdictions vary, and some are tough in other areas and weak in other areas, so I hesitate to identify——

Chairman STARK. Name three or four. Be bipartisan.

Mr. POMEROY. Let's take a hypothetical State. In the event there was a State——

Chairman STARK. What if someone was soliciting insurance by mail? Is that against the law in your State?

Mr. POMEROY. Yes; it is.

Chairman STARK. Is it against the Federal law?

Mr. POMEROY. It's against the law in my State.

Chairman STARK. How do you get a handle on it?

Mr. POMEROY. In the event we're aware that there's a policy out that hasn't been filed, reviewed and approved by us, we will take action against the company, ultimately resulting in a fine, which is the extent of our leverage in that instance.

The catastrophic act contained a similar comprehensive requirement for medigap policies. All policies coming into a market needed to be filed with the Department, so we have addressed that area. The long-term care model addresses the long-term care products which may be mass marketed.

As a practical reality, long-term care products, in my opinion, will not be very effectively mass marketed. They are simply too ex-

pensive for a person to shop through a mailer and decide to make the insurance purchase.

I believe the initial experience, for example, that AARP——

Chairman STARK. Unless they're really scruffy products.

Mr. POMEROY. That would be true, although again, I think the regulations would prohibit that type of product.

Chairman STARK. Well, it would be helpful to the committee. First of all, it's really a matter of indifference to me who regulates these products, as long as someone is doing it. It sure isn't going to be the market. I don't think that seniors are capable of protecting themselves against some unscrupulous operators. Now, whether you do it or we do it is a matter of indifference. The real question is then how do we help you do it, or how do we help protect the people in States that don't have as energetic insurance regulations? What can we do to spread the word, as it were?

Minimum Federal standards that are, in effect, your standards, does that bother you? Let's take the hypothetical State that doesn't have any regulation. If I impose your regulation on them as a minimum, does that trouble you?

Mr. POMEROY. It troubles me to this extent. The model has been evolving, which is a nice way of saying we've changed it every time NAIC has had a plenary session since 1986. To freeze upon the States our present standards, in my opinion, would fail to permit the ongoing evolution of those standards.

In addition, the market is rapidly developing. We have seen the growth of a meaningful group insurance product. I expect that there will be products that voluntarily wrap in nonforfeiture values and marketed to younger age groups. We have seen products now with tied on life products.

As we wrestle with regulating this moving target, we at the NAIC level will be, from a hands-on and very technical perspective, continuing to evolve our regulatory standards.

I am not certain how you impose, federally, a set of standards that are growing and developing.

Chairman STARK. We may not be as quick and efficient and thorough as you are, but let's take this hypothetical State which is never going to come into the club and join up with you. So even if we followed behind you a year or two—and let's assume you're tightening the standards, generally—if we just impose your standards as a Federal minimum, and then even if it's a year or two later, and say anyone who exceeds these standards is home free, assuming you believe in your standards, wouldn't that be a good thing to do for the country at large?

Mr. POMEROY. I certainly believe in our standards.

I believe it would be untimely now. States are moving fast. Again, within 2 years, if we sit at this table and look at a map where major States have not put some meaningful protections in place, I would be hard-pressed to tell you we don't need Federal standards.

At the present time, I think it's important to note that the NAIC standards came on line in 1986, before the market growth we've seen. A number of States in the first cycle of legislatures in 1987 adopted it, a number of more in the 1989 cycle of legislatures have adopted it. But it does take time to get these things in place at a

State-by-State level, and I think we're well on track to having a comprehensive adoption within 2 years.

Chairman STARK. And you think you're going to have protection against inflation in your standards?

Mr. POMEROY. I think the approach we may be looking at is a dual offer mandate. There will be a range of purchasers at advanced ages—for example, the upper seventies—that want protection and will not be able to afford the protection in the event it's mandated. It seems to me they ought to be able to choose between a policy that contains that benefit and one that does not.

Again, in the case of a rural family, you often have a situation where there's an asset-rich family with very limited cash flow. So you could load in a wonderful series of benefits but no one can afford it any more. I don't think the public has been well-served by a regulatory response of that nature.

Chairman STARK. Well, will you submit to us some of your suggestions for an outline of the criminal issue as related to agents? That would be helpful to the committee.

Mr. POMEROY. We would be happy to. We have some pretty clear idea of where we think some changes must be made in the medigap market relative to criminal sanctions. We're not as advanced in the long-term care market, but we'll get at it right away.

Chairman STARK. Mrs. Johnson.

Mrs. JOHNSON. Thank you very much, Mr. Chairman.

I appreciate your testimony very much and congratulate the commissioners for examining this issue appropriately early. As an old State legislator, I am very impressed that in essentially two legislative cycles 36 of the 50 States have moved along.

I am equally impressed with your ability to respond on an annual basis and to stay in close touch with both consumers and providers in order to adjust the model regulation.

Is there any significant movement in the market to allow conversion of life insurance policies long-term care coverage on the basis of annuity? I know there are some new policies of that sort.

Mr. POMEROY. Congresswoman, there are new life policies offering a long-term care benefit. I'm not aware of an existing life product that is adding a conversion after the fact. I'm not aware of that development. Yet, I believe the industry has been quite responsive to the market needs, although it has been primarily geared toward the marketing of new products. To simply add that benefit without additional marketing effort probably will not be forthcoming.

Mrs. JOHNSON. Thank you.

Last, have you and your fellow commissioners considered ways to facilitate our senior citizens' ability to shop in the long-term care market by creating symbols that designate certain levels of conformity and consumer protection? It seems to me there are certain things such as whether the policy is cancelable, or whether it requires prehospitalization that could be indicated symbolically and be of great help to the seniors in sorting out policies. There must be four or five things that elderly people particularly need to know and about which they are easily misled.

Mr. POMEROY. That's an excellent suggestion.

We recognize that an educated consumer will not be a defrauded consumer. We place substantial efforts in consumer education. A

number of commissioners, including myself, will routinely conduct insurance forums for senior citizens. We have published buyers' guides and will soon be implementing a model, a long-term care insurance buyers' guide.

At the suggestion of Consumers Union, which was an excellent suggestion, we now mandate a uniform benefit disclosure format so that an individual will be able to have a series of policies and meaningfully comparison shop, one to another.

Relative to some overt identification of some of the major loopholes of the policies, our approach has been to simply prohibit the major loopholes, the 3-day prior hospitalization as an example.

Yet, we must understand, as regulators, that it's still a very difficult prospect to shop for this insurance and do everything we can to make it more simple.

The reservations I have, for example, about grading policies would be that a policy would be constructed to achieve the letter grade and yet have some major soft spots within it. So that's a very difficult regulatory task when you attempt some standardization or grading mechanism for purposes of assisting the public. It can also be used to mislead the public if those standards aren't carefully drawn.

Mrs. JOHNSON. I appreciate that.

Thank you for your testimony.

Mr. POMEROY. Thank you.

Chairman STARK. Commissioner Pomeroy, how many brothers do you have? [Laughter.]

Mr. POMEROY. Only one.

Chairman STARK. OK. So the job of attorney general is still open. I just thought, if we do regulate insurance companies, and you're looking for work, I wanted to make sure there was a place for you in State government that wasn't already filled by your family. [Laughter.]

Thank you. Your work in this area is well known to this committee. If everybody in the regulatory community took as farsighted concern as you do, I don't think these hearings would be necessary at all. I appreciate your taking the time, and I hope we can work together to both reinforce the good work you're doing and, in whatever way we can, to encourage other States to see the light and join in.

Mr. POMEROY. Mr. Chairman, I appreciate that comment very much. I would add that your interest and H.R. 1325 in this hearing this morning has served as substantial motivation within the States to bring their own standards on line. So your interest and oversight in and of themselves serve a helpful role to us.

Thank you.

Chairman STARK. Thank you very much.

Our final panel is comprised of Mr. Bruce Boyd, chairman of the Health Insurance Association of America's Long Term Care Task Force, and coincidentally, vice president of the Teachers Insurance and Annuity Association in New York, and Miss Mary Nell Lehnhard, vice president of Blue Cross and Blue Shield Association.

The Chair would like to welcome you to the committee. Mr. Boyd, would you like to lead off?

STATEMENT OF BRUCE L. BOYD, VICE PRESIDENT, TEACHERS INSURANCE AND ANNUITY ASSOCIATION/COLLEGE RETIREMENT EQUITIES FUND, APPEARING ON BEHALF OF THE HEALTH INSURANCE ASSOCIATION OF AMERICA

Mr. BOYD. Good morning, Mr. Chairman, and members of the subcommittee. I would like to begin by saying that all of us want effective consumer protection for people who purchase long-term care insurance.

My purpose today is to inform you of our own efforts in this regard, to indicate why we think Federal standards are not appropriate, and to highlight a few ways in which we believe H.R. 1325 can be enhanced.

We have submitted written comments for the record. I will address a few of the key issues at this time.

Our task force recently presented and the HIAA board approved a comprehensive consumer protection paper. It focused on four areas: the legislation and regulation that already exists to protect the consumer, including the NAIC long-term care model; the need for disclosure and increased education for the consumer; the need for appropriate marketing and sales practices by those selling long-term care insurance; and specific policy provisions that should be part of long term care plans.

This was a strong statement in support of consumer protection and also of the State regulation of insurance. We believe the NAIC has been both energetic and responsible in addressing long-term care insurance.

Over 30 States have adopted legislation and regulation at least as stringent as that of the NAIC model, and legislation is currently pending in 9 other States.

Our objection to Federal standards is based on our belief that the States are being responsive and responsible. We believe it would be difficult to coordinate dual Federal and State standards as needs change. Dual standards will make it more difficult and expensive for insurance companies to monitor and assure compliance.

There is a need for flexibility as new product forms emerge, and we believe that the NAIC is particularly well suited to deal with the complicated issues which are likely to arise as experimentation with a variety of funding and insuring mechanisms develop.

It is also our belief that the current legislative and regulatory framework, if properly enforced, does provide the necessary protection to the consumer.

We will be pleased to meet with you or your staff to discuss our specific suggestions with respect to H.R. 1325. I would like to just mention two at this time.

First, increasing the minimum duration of coverage to qualify as a long-term care policy from 12 to 24 months. There is a growing consensus among researchers, State regulators and the insurance community that it is premature to change the minimum 12-month period. Twelve months covers over half the nursing homes stays and is less expensive than a policy covering 24 months.

Increasing the minimum period to 24 months would tend to disproportionately impact lower income people and perhaps eliminate long-term care insurance as a funding option for them.

The bill, in addition, we don't believe sufficiently differentiates between individual and group insurance. The design of these products often requires different approaches to reach the same end. For instance, the continued availability of coverage is assured through a guaranteed renewable provision under individual policies, whereas conversion or continuation of coverage is more appropriate under a group plan.

To allow various approaches of insuring and funding to develop, we believe it is necessary to address such differences

Our industry is committed to consumer protection. Instances of wrongdoing have been brought to our attention, and each reflects poorly on us. However, overall, we have an excellent record of helping millions of Americans protect themselves against financial loss.

No entity, public or private, should be judged solely by the worst of its deeds, although each is surely impacted by them.

The HIAA, through development of the consumer guide, which has been circulated to more than a million people, through the consumer protection paper which establishes a strong position on consumer protection, and through its efforts currently underway, to develop comprehensive approaches to financing long-term care for all Americans, continues to demonstrate its concern for and dedication to the consumer. It is my belief that there is no greater consumer advocate than one who is willing to devote the time, the effort and the capital to bring a product of true value to the marketplace.

Thank you very much.

[The statement of Bruce L. Boyd follows:]

Statement

of the

Health Insurance Association of America

Good morning Mr. Chairman and Members of the Subcommittee. My name is Bruce Boyd, Vice President of TIAA/CREF. As Chairman of the Long-Term Care Task Force, I am speaking on behalf of the Health Insurance Association of America (HIAA), which represents some 350 insurance companies writing over 85 percent of all commercial health insurance in this country.

HIAA strongly supports consumer protection for all health insurance products. HIAA recognizes that this is particularly critical for long-term care insurance.

Long-term care insurance is one of the newest and most rapidly growing forms of insurance. Historically, long-term care has not been well understood by either consumers or insurers. Both need to become better informed for long-term care insurance to become a viable product. The value of such a product is clear -- it allows consumers to protect themselves against the potentially devastating cost of long-term care.

We want our member companies to offer products that balance consumer protection and consumer choice with product affordability and financial integrity.

Because this issue is of highest priority to the Association, a Board-level Task Force on Long-Term Care spent the past year reviewing existing consumer protection measures that cover long-term care insurance and developing recommendations that address the design and sale of long-term care insurance products. From this work, a policy statement on consumer protection was adopted by our Board of Directors in February. Let me highlight the most important points of that document in my remarks today.

Our consumer protection paper focused on several areas. These were:

- The legislative and regulatory environment that already governs the sale of insurance, including long-term care insurance,
- The education and disclosure needs of consumers in the marketplace,
- The marketing and sales practices of companies and agents selling individual products, and
- The policy provisions contained within long-term care insurance contracts.

I will discuss each of these areas separately.

LEGISLATIVE AND REGULATORY ENVIRONMENT

HIAA strongly supports the state regulation of insurance. More specifically, HIAA strongly supports the National Association of Insurance Commissioners' (NAIC), long-term care insurance model act and regulation as amended in December 1988. We believe that the model act and regulation offer the most appropriate means for protecting consumers and the developing marketplace.

The NAIC should be commended for its leadership role in recognizing the need to govern an emerging new insurance product.

When they first took up this issue in 1985, fewer than 20 companies were selling what has come to be defined as long-term care insurance. Indeed, part of the problem in counting these earlier plans is that there were no standards for identifying them.

Today, over 100 companies sell a long-term care insurance plan which meets the definition of such a plan as contained in the NAIC model act. The NAIC's timely and thoughtful response has helped create a viable product for an event that many said was uninsurable only a few short years ago.

Since December 1986, when the NAIC first adopted the long-term care insurance model act, over 30 states have adopted substantially similar or more stringent laws or regulations governing long-term care insurance. Legislation is currently pending in another 9 states. And, perhaps even more indicative of the states' responsiveness, 14 states have pending amendments to their long-term care insurance laws that reflect recent NAIC amendments to the model act.

One of HIAA's highest priorities is the passage of the NAIC model act in those states that have not yet adopted it. Our staff have been directed to work with the state legislatures and insurance departments to accomplish this goal in 1989. Furthermore, the President of HIAA has urged its member companies, in a letter to all C.E.O.s, to seriously consider following the standards of the model act and regulation in those states that have not yet adopted either.

HIAA continues to support other NAIC model acts and regulations that protect purchasers of insurance. These models, such as the Unfair Trade Practices act and the Rules Governing Advertisement of Accident and Sickness Insurance, are in widespread use by the states to protect all citizens, including those purchasing long-term care insurance.

EDUCATION AND DISCLOSURE

We believe that an informed public is the true key to consumer protection. Therefore, we support the broadest possible educational efforts in this area.

For your information, I have submitted HIAA's second edition of the Consumer Guide to Long-Term Care Insurance for the record. The requests for this Guide have been overwhelming. Between the two editions, over 1 million copies have been distributed. While we will continue our efforts, we believe that the state and federal governments must also do more to educate the public about long-term care, their risks of needing it, and options for getting help and paying for it.

To help consumers understand long-term care insurance policies, HIAA supports company use of a policy disclosure document, offered at the point of solicitation, that would allow people to compare different policies' benefits, limitations and exclusions. The HIAA Consumer Guide provided a checklist to help consumers make such comparisons.

The disclosure outline of coverage, recently added to the model regulation by the NAIC, will provide consumers, in plain language, a uniform summary of each policy they examine. The outline of coverage must be a free-standing document, printed in at least ten point type, that spells out, in a standard format, several features of the policy. These include:

- Terms under which the policy or certificate may be returned and premium refunded and whether or not the policy has provisions for a refund or partial refund of

premium upon the death of an insured or surrender of the policy;

- A statement that "This is not Medicare supplement coverage."
- A description of institutional and noninstitutional benefits,including the level(s) of care provided, and how one becomes eligible for benefits;
- A description of limitations and exclusions, including preexisting conditions and non-eligible facilities, providers and levels of care;
- A statement that "This policy may not cover all the expenses associated with your long-term care needs";
- A statement as to whether the benefits increase over time, whether it is automatic or a guaranteed option, whether additional underwriting is required, and whether additional premiums will be charged and how they will be calculated; and
- A description of the renewability provisions and under what conditions premiums can be increased.

Consumers will benefit greatly from this information. Only by comparing different policies across the same features, will they understand this insurance coverage and be able to choose a product that best meets their individual needs.

MARKETING PRACTICES

While consumer education is essential and disclosure requirements will accurately describe the product, it is up to company marketing personnel to accurately represent the sale of the product. We believe that existing state laws adequately protect consumers buying health insurance. However, because of the vulnerable elderly population that may purchase long-term care insurance on an individual basis, HIAA supports additional steps in the marketing and sale of this product.

HIAA believes that companies must devote additional time and resources toward educating insurance marketing personnel about long-term care insurance. HIAA believes that the state licensing exam for health and life insurance agents should include questions on long-term care insurance. We also recommend that companies ensure that their quality review programs for marketing personnel address the special concerns of selling long-term care insurance.

POLICY PROVISIONS

HIAA firmly supports the policy provisions that have been developed, after thoughtful deliberation, by the NAIC. Moreover, HIAA recommends that its member companies consider offering benefits that periodically increase over time and we will continue to work with the NAIC to address this provision and others as they are identified.

H. R. 1325

The ability and readiness of the states to effectively react to the evolving nature of long-term care insurance is clear. This market is still being defined and change is more the norm than the exception. Long-term care insurance is not just a health product -- life and disability income models are also evolving rapidly.

When we look at how far the market has come in the last 2 years and where it might be 2 years from now, it is guesswork, at best, that the provisions of this bill define the best that the market can offer. Moreover, it will be an ongoing legislative process to continuously update this bill to reflect future and expected NAIC changes to the model act and regulation.

In addition, unlike Medicare supplement policies, there are no well defined "gaps" for the private market to fill. H.R. 1325 would apply federal standards to a purely private insurance product that has not yet matured.

The NAIC, through amendments to the original model bill and regulation, and the states, through continuing legislative and regulatory modifications, have recognized a need for and achieved a balance between the developmental growth of a new product and consumer protection and affordability.

At this point in time, HIAA does not believe that the federal government can offer the same degree of flexibility and innovation needed to allow this market to work.

In addition to the issues raised above, H.R. 1325 departs in significant ways from the NAIC model act and regulation. Most noteworthy, the bill establishes separate standards for two types of long-term care insurance policies -- those providing at least 24 months of coverage and those providing from 6 months to 24 months of coverage. These artificial distinctions were considered by the NAIC, but have since been rejected after discussions with several long-term care research experts. Based on a consensus of the research, state regulator and insurer community, H.R. 1325 should replace this provision with the original 12-month minimum definition contained in the model act.

The bill also attempts to regulate two conceptually different types of insurance products as one. While we support similar goals for individual and group policies, the design and administration of group and individual plans often require different paths to reach the same place. For example, group plans offer "guaranteed renewability" through continuation and conversion requirements. Requiring both, as H.R. 1325 does, is not appropriate.

It is unclear how H.R. 1325 affects products offered to persons ineligible for Medicare, especially those covered by employer-sponsored plans. Would an employer be required to provide separate provisions, such as free-look periods and different preexisting condition periods, to their employees or retirees over 65? Employers seek the best product for the best price; this bill could inhibit that ability. And, we believe that the employer market offers the greatest potential for reaching the most people.

There are other provisions in the bill that concern us. These include the expanded language for covering persons with Alzheimers disease and added responsibilities, which could be quite costly, for state insurance departments. We welcome the opportunity to meet with you or your staff to discuss these issues in more detail.

CONCLUSION

We all agree that solving the nation's long-term care financing problem is vitally important. HIAA believes that the flexibility of private insurance offers many elderly and their families a preferred approach to using private resources or Medicaid. And, private insurance is the appropriate vehicle for allowing families to preserve their financial assets. This is not the role of a government program. Fostering the private market is an investment that will pay off many times over by preventing an

unsupportable tax burden from being placed on our children to pay for you and me.

Thank you Mr. Chairman and Members of the Subcommittee. I would be happy to answer any questions that you might have.

[THE ATTACHMENT SUBMITTED WITH THIS STATEMENT IS BEING RETAINED IN THE COMMITTEE FILES.]

Chairman STARK. Thank you.
Miss Lehnhard.

STATEMENT OF MARY NELL LEHNHARD, VICE PRESIDENT, BLUE CROSS AND BLUE SHIELD ASSOCIATION

Ms. LEHNHARD. Mr. Chairman, Mrs. Johnson, I am Mary Nell Lehnhard, vice president of the Blue Cross and Blue Shield Association.

We appreciate this opportunity to comment on the establish ment of the Federal voluntary certification program for long-term care policies.

Sixteen Blue Cross and Blue Shield plans are now marketing long-term care products, and we expect several more plans to introduce products in 1989.

Descriptions of some of our products are included in our testimony, and I would only note that these products have developed significantly over time. They offer a much broader spectrum of benefits and a much greater level of protection than the first policies we put on the market. Certainly we expect our products to continue to evolve to meet the demands of consumers.

The Blue Cross and Blue Shield Association supports the strong leadership role taken by the NAIC in developing standards for State regulation of these products. We believe that the prompt action taken by 19 States, and the fact that 7 other States have developed similar language for introduction this year, demonstrates the strong commitment to appropriate regulation of this market.

We believe that many more States than these 26 will adopt regulatory programs at least as stringent as the NAIC model.

In addition, we think that as these products have matured, and the capability to offer more protection has developed, the NAIC has reacted promptly to this and revised their original 1986 model language. Given the dynamic nature of the model standards which were revised in 1988, and will be further amended in 1989, and the State regulatory and legislative activities, we believe that Federal action should be deferred for adoption at this time.

However, if the Congress does conclude that a Federal program is necessary, we would support exactly what you were discussing with Commissioner Pomeroy, Mr. Chairman, a Federal voluntary certification program that incorporates the standards developed by the NAIC.

We are pleased that your proposal does recognize the work done by the NAIC in developing a market that allows for evolution of these products. However, the proposal does include a number of revisions to the NAIC's work, some new standards, and some general blanket authority for the Secretary to establish further standards.

We would urge that if the subcommittee decides to take action on the bill, that it incorporate only the NAIC standards, while retaining the proposed criminal sanctions for abusive marketing practices.

We want to thank you for this opportunity to testify, and we will be pleased to work with you as you work on this bill further.

[The statement of Mary Nell Lehnhard follows:]

STATEMENT OF BLUE CROSS AND BLUE SHIELD

Mr. Chairman, and Members of the Subcommittee, I am Mary Nell Lehnhard, Vice President of the Blue Cross and Blue Shield Association. The Association is the coordinating organization for the 75 Blue Cross and Blue Shield Plans throughout the nation. Collectively, the Plans provide health benefits protection for more than 100 million Americans.

We appreciate this opportunity to discuss private sector initiatives in developing and marketing long term care insurance and to comment on the establishment of a federal voluntary certification program for private long term care insurance.

Blue Cross and Blue Shield Long Term Care Activities

Sixteen Blue Cross and Blue Shield Plans are now marketing long term care products, with several more expected to introduce products in 1989. Typical Blue Cross and Blue Shield long term care policies may be purchased by persons between the ages of 50 and 79. However, this varies among Plans, with some Plans offering benefits to individuals as young as age 18 and as old as age 85.

Along with care provided in nursing homes, individual long term care benefit programs may cover a wide variety of home and community-based health services, including home health visits, adult day care, homemaker services, respite care, medical transportation, and case management also known as care coordination.

Premiums vary with age at initial purchase and with benefit options selected. Rates are set at a level that will, over an expected lifetime, accumulate funds necessary to meet the increasing need for services in later years.

Due to the lack of data on utilization and the unpredictability of the future costs of long term care, most of the industry's early long term care policies were quite restrictive. These policies predominantly offered only nursing home coverage and usually had requirements such as prior hospitalization before benefit eligibility was triggered. Alternative levels of care, such as home health or custodial care, were seldom offered.

In contrast, more recent long term care insurance policies developed by Blue Cross and Blue Shield Plans and others tend to offer benefits that are tailored to meet a variety of long term care needs. For example, the majority of Blue Cross and Blue Shield Plan policies provide extensive coverage for home care and care coordination. Care coordination programs assist subscribers and their families in assessing an individual's particular needs in order to determine the most appropriate setting for the delivery of services.

Blue Cross and Blue Shield Plans also offer a wide range of benefit payment designs, ranging from the more traditional "service" benefits which base payment on a percentage of the cost of services received to a fixed indemnity amount of so many dollars per day. The "service" payment structure assures individuals that their coverage will keep pace with inflation. Several Plans combine the two to offer a service benefit with a dollar cap. Some policies also protect against inflation by incorporating features such as annual percentage increases for covered services or periodic opportunities to increase benefit levels.

While most long term care policies are designed to be purchased by individuals, a number of new Blue Cross and Blue Shield policies have recently been introduced for groups. In fact,

Blue Cross and Blue Shield of Rochester (NY) provides fully paid long term care coverage to its own employees who are age 55 or older. Two other Blue Cross and Blue Shield Plans, Michigan and Kentucky, are involved in an innovative employer-contribution, group long term care program offered by the Ford Motor Company. This two-year demonstration program was recently made available to Ford/UAW employees at two Ford facilities in Louisville, Kentucky.

A brief description of some of our products illustrates how these features may be combined into a long term care insurance package.

Blue Cross and Blue Shield of the Rochester (NY) Area, along with offering its employees fully paid long term care benefits, offers coverage in a full range of settings, including nursing homes, adult day care centers and individual homes. "Care Directions," offered through a subsidiary of the Rochester Plan, has several coverage options. Persons aged 21 through 85 may select any of the three benefit payment options: a product that covers 75 percent of costs for long term care, a product that covers a fixed daily amount for care; and a product that combines a fixed daily amount of coverage for nursing home care with 75 percent coverage for home care and adult day care services. None of the policies require that the policyholder have a prior hospitalization or nursing home stay to qualify for benefits. A unique feature of these policies is a "Patient Advocate" who will personally assist the policyholder and the family in planning for LTC services. Patient advocates are registered nurses or medical social workers who are supported by a LTC-trained medical director. The policy also offers a "paid-up" benefit option. Under a paid-up benefit, an individual chooses to pay on a policy for a fixed amount of time, e.g. 10 or 20 years. After that time, premium payments are no longer necessary.

Blue Cross and Blue Shield of Connecticut's "Century Gold Plus" provides coverage for all levels of nursing home and home health care including: skilled nursing care, therapies, home health aide services, chore services, home-delivered meals, medical supplies and medically necessary transportation to and from the hospital and doctor's office. The policy uses a service-based approach and pays up to 100 percent of the average cost in the community of nursing home care (set at $95/day in 1988) and home health services (set at $40/visit in 1988) and 75 percent of the cost of homemaker and adult day health care services. The policy is available to individuals aged 40 through 79 and includes a comprehensive care coordination program. The policy also offers optional features such as paid-up benefits, and annual inflation increases.

Blue Cross and Blue Shield of Iowa offers "Long Term Care Coverage" to individuals age 18 to 79. This product covers all levels of nursing home care, home health care, and adult day care. In addition, the policy provides special features such as spousal discounts, annual inflation adjustments and care coordination benefits. The policy offers 3 or 5 years of coverage under 4 different benefit options.

Long Term Care Standards

On March 8, 1989, Chairman Stark introduced the "Consumer Protection for Long Term Care Insurance Act of 1989", H.R. 1325. This bill would establish a voluntary federal certification program under which insurers could seek certification of their long term care policies. The standards to be used would reflect those developed by the National Association of Insurance Commissioners (NAIC) as well as revisions to NAIC standards and would set forth several new standards. H.R. 1325 also gives the Department of Health and Human Services full discretion in developing additional standards.

We are pleased that the Chairman's proposal for a voluntary certification program recognizes the extensive work done by state regulators, consumer groups, and the insurance industry in developing a regulatory environment that allows for the development of this market. However, we are concerned about revising such standards and developing new standards without relying on the technical expertise of the NAIC and its advisory panel.

The Association supports the leadership role taken by the NAIC in developing model standards for state regulation of long term care insurance policies. We believe that the prompt action taken by the 19 states that have adopted the NAIC model LTC standards, the 7 states that have developed similar language, and the additional states that have chosen to regulate this market through agent and carrier conduct regulations, demonstrates their commitment to appropriate regulation of this emerging market. We believe that many more states will adopt LTC regulatory programs at least as stringent as the NAIC model.

In addition, we believe that, as the long term care products have matured and developed the capability to offer more protection to consumers, the NAIC has promptly revised the original 1986 model language to include these innovations. These include adoption of specific conversion requirements, an outline of coverage requirement and a no prior hospitalization provision. Likewise considerable attention is being given to investigating the effect of other revisions such as the minimum length of long term care policies.

Given the dynamic nature both of the model standards, which were revised in December 1988 and will be further amended in 1989, and state legislative and regulatory activities, we believe that the federal government should defer legislative action at this time.

If, however, Congress concludes that the establishment of a federal voluntary certification program for long term care insurance policies is necessary to encourage state efforts in this area, we would support such action for long term care products provided that the voluntary federal certification program incorporates the standards developed by the NAIC. We could not support the development of revisions to them or new standards. Thus, if the subcommittee decides to take action on H.R. 1325, we recommend amending the bill to incorporate only NAIC model standards while retaining the proposed criminal penalties for sales abuses. We would also recommend that if Congress enacts a voluntary certification program based on the NAIC model standards, it monitor future changes in the NAIC standards and promptly revise the federal legislation as necessary.

Enactment of a federal voluntary certification program that relies on NAIC model act and regulations would assure that appropriate federal efforts to protect consumers who buy long term care insurance are based on the expertise of the nation's insurance commissioners, without duplicating or supplanting State regulatory authorities.

There is ample precedent for this approach. In the 1980 legislation establishing the voluntary federal certification program for Medicare supplemental insurance policies, Congress incorporated by reference the standards developed by the NAIC. Again in 1988 when Congress enacted the Medicare Catastrophic Coverage Act, it provided for the incorporation of revised NAIC Medicare supplemental insurance standards into the federal certification program provided that the NAIC took prompt action in making those revisions it determined were appropriate.

The Challenge of Long Term Care Products

Long term care products have matured significantly since the original products were first introduced. Second and third generation products have been developed to respond to consumer preferences for guaranteed renewability, home health benefits, and no prior hospitalization options. In spite of the encouraging nature of new long term care insurance products, several issues remain to be addressed which would would encourage faster growth in the market. These include:

- o Public Misperception: First, although more and more attention is being paid to the problem of financing long term care, much of the public continues to believe that they already have coverage for long term care expenses through Medicare. While this perception is slowly changing, it is important to continue to educate the public about their lack of coverage for long term care.

- o Consumer Education: Unfortunately, not all consumers know how to assess a product's value. It is essential that consumers realize what they are buying and what questions to ask when looking for a policy, especially in a newly emerging market where policies change from year to year. It is encouraging to see a large number of long term care buyers' guides being developed by states, businesses, and various associations.

- o Inadequate Data: Another barrier to widespread long term care coverage is the lack of widely available actuarial experience on which to base premiums. Although there is a growing body of data on current utilization of nursing home and home health services, without experience it is difficult to use this data to predict utilization and cost trends ten and twenty years down the road.

- o Tax Issues: One of the most important problems associated with the slow expansion of long term care policies particularly in the group setting has to do with the clarification of long term care insurance for tax purposes. While a recent IRS Revenue Ruling addressed the tax treatment of insurers' long term care reserves, it specifically noted that insureds and employer tax exclusions and deductions for amounts paid to purchase long term care policies require legislative, not administrative clarification. We would urge that Congress provide such clarification as soon as possible.

Conclusion

In conclusion, the Blue Cross and Blue Shield Association stresses the need for continued regulatory flexibility at all levels of government to support the development of the newly emerging long term care market. We believe that the NAIC has been responsive to the long term care insurance market while still addressing consumers' needs. We also believe that the industry has been responsive to consumer demands.

However, if the federal government feels that a voluntary certification program for long term care policies is necessary for those states that do not adopt existing model language, we strongly recommend that the adopted federal insurance standards incorporate only those standards developed by the NAIC, not revisions to them or completely new standards. We would also urge the Congress to promptly revise federal legislation as necessary to incorporate any changes adopted by the NAIC.

We want to thank the subcommittee for this opportunity to present our views. We will be pleased to work with you as you continue to look at the issue of long term care.

Chairman STARK. Thank you.

Mr. Boyd, do you have any objection to the criminal sanctions that were suggested, on the marketing side?

Mr. BOYD. As I understand them, no, sir.

Chairman STARK. Teachers Insurance and Annuity sells, in effect, mutual funds?

Mr. BOYD. Essentially, it's a pension fund for higher education.

Chairman STARK. But it's purchasable in units by your members?

Mr. BOYD. Primarily, we offer pension plans to employees of educational institutions, often heavily contributed to by the employer. We also offer tax-deferred annuities.

Chairman STARK. If I were a teacher in New York State, what kind of products could I buy from you directly?

Mr. BOYD. None, really. We sell individual life insurance, but none of the pension nature. It's all through employer-sponsored programs.

Chairman STARK. OK. If I was in an employer-sponsored program, do I have flexibility in how much I can invest out of my paycheck?

Mr. BOYD. There are—I work on the group insurances side and I'm not that familiar with some of the pension provisions. I know there are limitations on the amount that can be directed to a pension program on a tax-deferred basis. Voluntary contributions could be put in——

Chairman STARK. But you do operate a stock fund and a tax-deferred fund?

Mr. BOYD. We have—yes, we have both the fixed and variable fund.

Chairman STARK. In those areas you are regulated both by the Federal Government and the State of New York, are you not?

Mr. BOYD. Sir, I'm really not familiar with the regulation on the pension side. I would presume, at least from the tax standpoint, we're regulated on the——

Chairman STARK. No, from the SEC standpoint.

Mr. BOYD. Our variable annuity is currently under SEC regulation, yes.

Chairman STARK. And that's not been a problem, has it, having both the Federal and State regulation?

Mr. BOYD. I can't answer that question.

Chairman STARK. I would be interested in it, if you would like to submit an answer. Because what I suspect is, in the great deal of objection we will hear to the regulation that the industry doesn't want, is just based on the fact that there are those of us who don't like regulation and the less regulation the better. That's understandable.

But we are dealing with, at least to my knowledge, the only industry that deals extensively with consumers that isn't under some Federal regulation, and that's the insurance industry. The purpose of our bill was certainly not to design the nose of the camel. What I do find is that it's somewhat confusing to have almost unanimous agreement that it would be good for the NAIC model to be adopted—you agree with that, don't you?

Mr. BOYD. Yes.

Chairman STARK. And you do?

Ms. LEHNHARD. Yes.

Chairman STARK. And maybe half the States will adopt it. That leaves half the States that may not or may adopt something less or, in fact, maybe something more stringent.

What I am having trouble finding as really any good reason that, from a Federal standpoint, we don't encourage or demand that they do it. What would you say to that? Your State, obviously, is going to do the right thing.

Mr. BOYD. I think I would respond exactly the way Commissioner Pomeroy did. We aren't arguing against standards. We are for the NAIC standards. We have endorsed those. We are encouraging member companies to consider abiding by those standards, even in States which have not yet enacted them. We are actively trying to assist in having them enacted in those States.

I think that is where we would like to concentrate our efforts right now. I think there is a good likelihood for a number of States to adopt this. It's more than half already and it really has not been in effect for a long period of time.

Chairman STARK. Well, what if we said that the only companies that would be regulated are those that do not subscribe to the NAIC standards and submit themselves voluntarily to its regulations?

Mr. BOYD. I still think we would like to push for the State regulation and to encourage that to be in force——

Chairman STARK. I'm with you. You and I are going down the same path. We've just got a few States that are going to say that you and I are both wrong, when we know deep in our hearts we're right.

Now, what would be wrong with saying look, if you join in and join the self-regulatory process then you're home free; for those who don't, we will insist that either you join, or if for some reason you don't join, then we will impose those same regulations.

Mr. BOYD. I think that if in a few years we found ourselves in that situation, I would probably be sitting here with Commissioner Pomeroy with a different opinion.

Chairman STARK. Well, how about if I save you the trip? I just say we'll write the bill to say that if by the end of 1990, or 1991, they are not in the box with the rest of you, doing the right thing, that all of you agree with your insurance commissioner is the right thing to do, those who have seen fit not to join will come under regulation.

This gives you a lot of time and a lot of incentive for people to join.

Mr. BOYD. I think if the other concerns that were raised were addressed, it would surely be far more palatable to me. The question is, can a Federal standard react as quickly. Would it be——

Chairman STARK. No, you're right. It cannot. That's why I say, if we just let you guys set the standards, I don't see anything wrong with that. We let the stock exchanges set standards and they change their stock exchange rules. Then we have different rules for those stocks that aren't listed and don't conform.

I don't know as there's anything wrong with that. It just is an encouragement for people to join. Then you and I would have nothing to argue about. I think the insurance commissioners have done

good work and I think, with the encouragement of everyone else signing up, you would have less competition from unregulated—let's assume they're not all unscrupulous, but just some who don't like regulation at all. But we level the playing field and you go ahead and compete. It has to be easier for you to accept; is that a fair statement?

Mr. BOYD. It would be far easier if Federal standards were a mirror reflection of the ongoing NAIC acceptable to the industry, yes.

Chairman STARK. How would Blue Cross feel about that?

Ms. LEHNHARD. Mr. Chairman, we think the States need a little more time. But I want to emphasize that if Congress decides to move now, we would be fully supportive of a voluntary Federal program if it embraced the NAIC model, as you were discussing, I don't think we would have any problem with a sort of 2-year or 1-year grace period.

Chairman STARK. You both agree that it would be helpful for us to try and define areas for the regulation of sales practices?

Ms. LEHNHARD. Absolutely.

Mr. BOYD. I think that would be fine.

Chairman STARK. Your suggestions in that regard would be most appreciated. I am not sure that we have the American Association of Independent Insurance Agents with us today, but I'm sure we'll hear from them before the Sun sets. It might be of some interest for you to suggest to us those areas in which the regulation is——

Are either of you familiar with this lead processing situation that we were discussing earlier, where companies send "scare" mail, what I would call it, and they go to great lengths to design their direct mail pieces so that it does not infer that it's an insurance or investment-oriented teaser? There is an application card that states, "Yes, tell me more about how I can protect myself from catastrophic incidents or being impoverished". They then sell these cards to agents, which I'm not sure is really insurance. They're really just prospecting companies.

But it seems there is some parallel between the people who use those types of schemes to get people to ask somebody—and it really doesn't say anybody is going to call on them. But it gives the lead-in to the salesman or whomever is going to call at the time.

Are you aware of that being a problem in New York?

Mr. BOYD. I really have no first-hand knowledge of that situation at all.

Chairman STARK. I'm sure Blue Cross doesn't use that type of solicitation.

Ms. LEHNHARD. I'm not even sure we use agents.

Chairman STARK. No, I think in some States you allow agents to sell it, don't you?

Ms. LEHNHARD. We use brokers, but I don't know about agents.

Chairman STARK. Mrs. Johnson.

Mrs. JOHNSON. Mr. Chairman, on that specific point, I'm concerned about adopting criminal penalties at the Federal level when the market currently is in such a state of confusion. It is absolutely no secret that the James Roosevelt people have been making statements on issues that are blatantly false.

The Congress has held hearings, we've written laws, we tried to stop them from using look-alike envelopes and all kinds of things. We've made a little progress, but not a lot.

Seniors now don't know what to believe, and I'm a little uncomfortable with injecting criminal penalties into that situation. We have not succeeded in communicating clearly to seniors that Medicare doesn't cover long-term care. The level of education and communication in the area of elderly benefits is not high. Do you feel confident beyond a shadow of a doubt, that your private companies could meet these tests?

If you were starting on a clean slate, I have no doubt that you could communicate clearly, we could hold you accountable and we could get you when you broke the law. But you're trying to communicate in an environment in which there has been blatant obfuscation.

Are you at all concerned about criminal penalties now looming on the horizon.

Mr. BOYD. I think we're concerned about the whole market practice with the product. A lot of what we have done, the consumer guide that we developed, is to give people a mode of comparison. I think disclosure is absolutely essential.

As mentioned, I think, by Josh Wiener previously, education is key to this.

One thing I would emphasize is I think we are dealing with two publics. You mentioned the one, and that's the current elderly. I think also we do have to effectively address people when they're younger and can afford, in larger numbers, to purchase the insurance, at a time when they're not likely to be impaired.

I have heard the criticism that long-term care insurance is too expensive at the older ages. That's true. It is not the appropriate time, in my mind, to buy long-term care insurance. The appropriate time is when someone is in good health and when someone can afford it and can fund it over a longer period of time. I think there, too, we have the opportunity to sell it through employers, where the education process is a lot easier, I feel, selling through an employer plan than individually to older individuals.

I have concern about the disclosure and the education in a one-on-one instance, and I think it is sometimes difficult to determine whether some one has done a complete job of describing the integration with Medicare or has gone overboard to indicate perhaps that the policy does something that it doesn't do. Two people can walk away from that encounter with different opinions, I think.

Mrs. JOHNSON. If you have any suggestions as to how those provisions might be clarified, I certainly believe we need to assure disclosure. I am glad to see the educational tools being used and becoming more refined, uniform and intelligible.

But just the fact that after all this time we've been unable to make the majority of the elderly understand that Medicare doesn't cover long-term care, doesn't give me a lot of confidence that even the best intentioned explanation of a long-term care policy would be received accurately. I have been in all the senior citizen centers in my district recently, discussing catastrophic care and I have found that I'm asked the same question over and over again. Communication with this population is a very difficult challenge and

I'm concerned about adding the issue of criminal penalties at this time.

Thank you.

Chairman STARK. If the gentlelady would yield, I think it was in the testimony that there were two levels of criminal penalties here. I don't think we were discussing with the witnesses the penalties on the company. It was the insurance commissioners who suggested they would like to see criminal penalties on agents who broke State laws by, in effect, lying to seniors about what a policy did cover, because their only remedy now is to take their license away. They feel that is not a stiff enough penalty to keep unscrupulous salespeople from the fragile nature of the consumer who's buying this.

So it was the fact that State regulators suggested that some Federal criminal penalties for misrepresentation would be useful, not dealing with the companies and the policies themselves.

Mrs. JOHNSON. Thank you, Mr. Chairman. I did seek to look at the exact language of your bill before I asked that question.

Chairman STARK. What's in my bill is not what they're looking for, in terms of criminal penalties.

Mrs. JOHNSON. I appreciate that clarification.

I think agents, though, would be particularly vulnerable. I mean, that's exactly the situation, now that I've answered the same question over and over again. I fear how my explanation is heard and how variously it's heard. I mean, some hear it one way, some hear it another. I'm not sure that the individual agents can be held criminally liable, except for very clear—I understand there are gray areas. I certainly think the insurance commissioners are doing a good job in trying to screw down on that.

I just wanted to express my concern about the possibility of criminal penalties in an area where communication has been so unsuccessful to this point.

Thank you.

Chairman STARK. I thank the panel very much for their testimony. The hearing is complete. Thank you.

[Whereupon, at 1:10 p.m., the subcommittee was adjourned.]

[Submissions for the record follow:]

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JAMES H. SAMMONS, M.D.
Executive Vice President
(645-4300)

May 31, 1989

The Honorable Fortney (Pete) Stark
Chairman
Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives
Longworth House Office Building Room 1114
Washington, D.C. 20515

RE: Submission for the Record of the Subcommittee on Health's May 18, 1989, Hearing on Standards for Private Long-Term Care Insurance

Dear Chairman Stark:

The American Medical Association commends you and other members of the Subcommitee on Health for your interest in the issue of long-term care and for having taken the time on May 18, 1989, to conduct a hearing on standards for private long-term care insurance. We ask that this letter and the accompanying AMA proposal for financing long-term care insurance be included in the record of that hearing.

The AMA is hopeful that Congress will, in the near future, address the difficult problem of financing long-term care for the American public, which is rapidly growing older. It is our position that the best solution will entail both public and private funding efforts. Our own proposal, which is attached, calls for the establishment of tax incentives to encourage the development of a market for long-term care insurance that would be used by individuals to protect the assets that they and their families have spent lifetimes to acquire. Individuals would be required to spend down unprotected assets, then would become eligible for long-term care benefits under the Medicaid program. The AMA envisions that a system of standards for these long-term care policies would be necessary.

The AMA encourages the Subcommittee on Health to consider our proposal. If Congress is unable to agree to a comprehensive long-term care financing program, however, legislation should be pursued to provide tax code changes that allow insurance companies, employers and employees, and others to treat long-term care insurance as health care insurance now is treated. This would encourage the development of a wide market for such policies. Legislation to provide standards for long-term care insurance and to provide protections from unscrupulous marketing practices should also be enacted.

The AMA is encouraged by the Subcommittee's interest in long-term care. We stand ready to work with you and others in Congress to bring about legislation that will both encourage necessary private financing and provide adequate public financing of long-term care.

Sincerely,

James H. Sammons, M.D.

REPORT OF THE BOARD OF TRUSTEES

Report: X
(I-88)

Subject: Long-Term Care Financing

Presented by: John J. Ring, MD, Chairman

Referred to: Reference Committee G
(Robert H. Shackelford, MD, Chairman)

The Association has in the past several years developed and put forward major new proposals to restructure the current Medicare and Medicaid programs and to address the problems of the uninsured. The Association's efforts in these initiatives have been directed toward improving access to needed care and placing the programs on a firm financial and a rational operational basis for the future. Each proposal requires significant new funding that the AMA has argued is necessary to carry out this nation's commitment to health care.

Long-term care (LTC) is a fourth area of health-related concerns of national proportion for which the Association is committed to developing a comprehensive, practical solution in order to actively influence the ongoing legislative and public discourse concerning the financing and delivery of LTC services. Public concern about family impoverishment and dissipation of assets after a lifetime of work is increasing pressure for a public response to these problems.

The Council on Legislation and the Council on Medical Service have reviewed a variety of alternative directions that the Association can take in developing an LTC solution. A critical factor that the Councils have taken into consideration is the fast-moving congressional activity that is likely to result in early consideration of an LTC program.

As a result, in large part, of Rep. Claude Pepper's efforts for consideration of an LTC home health care bill (HR 2762) in June 1988 and the creation of an acute care catastrophic benefit under Medicare (PL 100-360) in July 1988, a variety of LTC legislative proposals have been introduced in the 100th Congress. These have included comprehensive programs to set up whole new agencies to oversee the provision of LTC benefits, usually through Medicare; programs that would meld encouragement for the LTC insurance market with expansion of the LTC benefit under either the Medicare or Medicaid program; and programs to establish voluntary LTC policy certification with minimal federal involvement and no federal support.

Following the procedural defeat of Representative Pepper's home health care legislation, congressional leaders vowed to return to the LTC issue in the 101st Congress beginning next year. It is expected that the Association will be faced with congressional hearings on this issue early in the 101st Congress. The Board and the Councils believe that the AMA should have a program established before debate on LTC again begins in the next Congress.

An AMA proposal for the financing and delivery of LTC services must follow the general principles on LTC set out in Board of Trustees Report O (A-88). These principles are sound and call for a LTC financing system that

- encourages privately prefunded LTC financing to the extent that personal income permits;
- assures access to needed services when personal resources are inadequate to finance care;
- protects personal autonomy and responsibility in the selection of LTC providers;
- prevents impoverishment of the individual or family in the face of extended or catastrophic LTC costs;
- covers needed services in a timely, coordinated manner in the least restrictive setting appropriate to the health care needs of the individual;
- coordinates benefits across LTC financing programs; and
- promotes family care giving.

These principles reflect a belief that the best approach to LTC financing is one based on the concept that neither the private nor the public sector can, by itself, completely respond to the growing demands of LTC.

To "encourage privately prefunded LTC financing to the extent personal income permits," a LTC program should encourage individuals to purchase LTC insurance as a method of protecting assets, often including a home, that they have worked throughout a lifetime to accumulate. People should not be forced to spend these assets down into poverty before LTC benefits are available to them, which is now the case.

Asset protection can be accomplished through a program whereby individuals would purchase LTC insurance, and, to the extent of the dollar value of the benefits provided by this insurance, such individuals would be able to protect the same dollar value level of assets. Once the LTC insurance benefits and unprotected assets are used, eligible individuals would receive LTC benefits under the Medicaid program.

This program would have the advantage of providing the insurance industry with specific dollar amount coverages in a market where benefits are now difficult to determine actuarially. It would also encourage individuals, or their families, to protect assets that families want to keep or pass on. In addition, a program that encourages this individual choice bypasses the difficult argument of setting fair spend-down requirements to be eligible for publicly funded LTC benefits.

This kind of program has been introduced in Congress by Rep. Barbara Kennelly (D-Conn.) as the "Partnership for Long-Term Care Act (HR 4631). Representative Kennelly has termed her proposal an "asset-waiver" program. The state of Connecticut has also proposed such a program to finance LTC on the state level.

An effective LTC program must also provide tax incentives to ensure that a LTC insurance market would be established, including treating LTC policies the same as health and accident policies are now treated, allowing deductibility and the exclusion of benefits from income under the Internal Revenue Code, and allowing nontaxable distributions from Individual Retirement Accounts (IRAs) and employee trusts or annuities to pay for LTC insurance and services. The establishment of a LTC insurance market would have the effect of (1) reducing government expenditures for social services by reducing the incentive to transfer assets in order to qualify for Medicaid and, thus, (2) free up monies for medical care under the Medicaid program.

An adequate LTC proposal must also "assure access to needed services when personal resources are inadequate to finance care." Consistent with current AMA policy for Medicaid, LTC benefits should be provided to all individuals with incomes up to 100% of the poverty level. Uniform eligibility is consistent with the dictates of Board of Trustees Report MM (A-86) on reforming the Medicare program and Board of Trustees Report UU (A-88) on reforming the Medicaid program. Individuals with incomes above the poverty level but with incomes that would not allow them to purchase LTC insurance on their own should be provided with sliding-scale subsidies based on income to purchase LTC insurance.

To promote family care giving, a program should provide a substantial tax deduction for those who take care of family members who would otherwise be eligible for care in LTC facilities.

Any program for LTC financing will require new sources of revenue. The Board and Councils believe that LTC financing should be separate and apart from medical care financing. Medical care programs should not be confused with social care programs. LTC is far different and must not take precedence over the provision of basic medical care through the established Medicare and Medicaid programs.

New revenue sources for LTC should be broadly based. The Board and Councils are concerned with proposed funding mechanisms contained in legislative proposals that call for the elimination of the $45,000 cap on income subject to the 1.45% Health Insurance tax. This is not the best source of revenue to fund a new LTC program. General revenue would be the most appropriate source of financing for a LTC program. If legislation is enacted to remove the existing cap, such legislation must make it clear that the new tax is separate from the Health Insurance tax and should be entitled a separate "Long-Term Care Tax."

The Board of Trustees recommends adoption of the following statement of policy:

A program to finance long-term care should

- provide LTC coverage through Medicaid for all individuals with income below 100% of the poverty level;
- provide sliding scale subsidies for the purchase of LTC coverage for individuals with income between 100-200% of the poverty level;
- encourage private sector LTC coverage through an asset protection program as described above;
- create tax incentives to allow individuals to deduct the cost of LTC coverage from income tax, to treat employer-provided coverage in the same fashion as health insurance coverage, and to allow tax-free withdrawals from IRAs and Employee Trusts for payment of LTC insurance premiums and expenses; and
- authorize a tax deduction or credit to encourage family care giving.

TESTIMONY OF ANDREW KOSKI
INSTITUTE ON LAW AND RIGHTS OF OLDER ADULTS
BROOKDALE CENTER ON AGING OF HUNTER COLLEGE

Good morning Mr. Chairman and members of the House Ways and Means Subcommittee on Health. My name is Andrew Koski. I am Public Policy Coordinator of the Institute on Law and Rights of Older Adults, part of the Brookdale Center on Aging of Hunter College. The Law Institute researches the laws and regulations pertaining to entitlements such as Medicare, Medicaid and Supplemental Security Income, and researches the continued unmet needs of elderly people. Also we conduct training on public benefits, for both service providers and for seniors. Of particular interest to today's hearing, we have examined the coverage offered by private long-term care insurance plans, and we have developed seminars and materials on this topic for seniors.

As a social worker in the aging field, I want to express my gratitude to Congressman Stark and the House Ways and Means Subcommittee on Health for holding this hearing. In 1988 more than 500,000 long term care policies were bought, bringing the total number of these policies to more than one million. With this number expected to increase further, it is very timely to examine the experience of these policies and to discuss the establishment of standards for such policies.

We have researched the role of private insurance policies in meeting the need for long term care and we have concluded that for most people this great need can not be met by the purchase of private policies. This is because the current plans:

a) are too expensive for the average senior;

b) contain provisions which restrict benefits for custodial nursing home and home care;

c) do not keep pace with inflation;

d) are not available to seniors with poor health;

e) are not offered to a younger population who have long-term care needs.

Even though increasing numbers of people are purchasing private long term care policies, such plans are expected to pay for only a small part of nursing home expenses over the next 25 years. It has been estimated that by the year 2016 private insurance may account for 7-12% of total nursing home expenditures and it would result in a small reduction in Medicaid's outlay for nursing home costs. (Alice M. Rivlin and Joshua M. Wiener, Caring for the Disabled Elderly Who Will Pay? The Brookings Institution, Washington, D.C., 1988, p.22).

We believe that the need for long term care can only be met by a federally funded social insurance program. This recognizes that the need for long term care is an insurable risk that should be spread among all generations and that the government can administer a program in a more cost-effective manner than the private sector so that it would be affordable. Until such a program is enacted, we support minimum standards for private long term care policies as one way to provide consumers with protection from the high cost of nursing home and home care expenses.

Minimum standards are also required because most insurance policies are written in terms that are incomprehensible by even those of us with graduate degrees. This leads to mass confusion on the part of consumers who can't understand what coverage they are being offered and thus cannot compare policies and make informed decisions. I have spoken to numerous groups of seniors and found that most people cannot understand what coverage they have under their existing health plans and that they cannot comprehend what is being offered by companies soliciting business for Medicare supplement and for long term care policies. Minimum standards will make it easier to compare policies and also will give some assurance that benefits will be available when they are needed.

We support the provisions of HR 5085 and of the National Association of Insurance Commissioners Model Act that policies:

1) be guaranteed renewable;

2) do not condition benefits on prior institutional requirements;

3) do not limit eligibility for benefits in a facility or in the community to those who have previously received a higher level of service;

4) do not provide coverage for skilled nursing care only or provide more coverage for skilled care in a facility than coverage for lower levels of care.

In addition we recommend that policies:

a) do not exclude coverage for mental/nervous disorders which have a demonstrable organic cause, such as Alzheimer's Disease and related dementias;

b) offer an option which provides coverage for mental illness, regardless of origin;

c) shall provide coverage for at least 2 years of home based, community or institutional services, with an option to select coverage for at least 4 years;

d) must offer a daily nursing home benefit of at least 80% of the average nursing home cost in the region in which it is offered;

e) must clearly state which medical conditions are not covered;

f) must have a system for appealing coverage decisions;

g) must offer an option to purchase coverage which keeps pace with inflation;

h) must have a minimum loss ratio of 65% for individual policies and 75% for group policies.

These are a few recommendations to improve the coverage of private policies. Also, funding should be provided to non-profit organizations so that they can assist individuals in understanding their current health insurance benefits, the gaps in their existing coverage for long term care and what benefits are available through private policies. The few programs which currently assist seniors on Medicare supplemental insurance matters have demonstrated the importance of their work and could be used as models for programs to help with long term care policies.

We know that you are giving serious consideration to protecting seniors in the area of long term care and thank you for the opportunity to present our views.

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March 30, 1989

APR 7

The Honorable Pete Stark, Chairman
Ways and Means Subcommittee on Health
1114 Longworth
Washington, D. C. 20515

Dear Mr. Chairman:

Enclosed are some comments submitted to me by Mr. Gyle Peterson, a constituent, regarding home health care. Mr. Peterson suffers from muscular dystrophy and for the most part is bed ridden because of this disease.

I have had the opportunity to visit personally with Mr. Peterson. Meeting him and learning of his situation has helped me understand on a more personal level the need for long term coverage for disabled and elderly individuals. I encourage you to give his comments your attention.

Sincerely,

Byron L. Dorgan
Member of Congress

BLD:glr
Enclosure

Thanks!

Honourable Members of the Committee:

My name is Gyle Peterson. I am 34 years old and have a crippling form of muscular dystrophy. I am writing in the hopes that the federal government, either by itself or along with state government, will provide home care funding for a specific group of handicapped individuals, which I will soon define.

My particular condition is this: In December of 1983 I got extremely sick. I was rushed to the hospital where they performed a tracheostomy on me after a couple of weeks. During my stay in the hospital, which was a long, fearful month, my doctor suggested to my parents, who were both approaching sixty at the time, that they should employ private-duty nurses to help take care of me, considering my father's insurance, which was through the public school system and would pay for the nursing.

That particular insurance policy, provided by Blue Cross/ Blue Shield, was a $500,000 major medical plan which paid for private-duty nursing care. My family was allowed to pay these nurses any dollar amount, whether it be $5 an hour or $50 an hour -- the policy, however, would run out that much sooner with higher salaries. My concern then, gentlemen, is what's going to heppen to me once this insurance runs out.

It's my hope and dream that in the next few minutes I will be able to help you to see things through the eyes of someone in my type of situation so that you can understand why it's vitally important to have legislation passed that would provide funding for specific handicapped people. I was hoping to be able to speak before this committee myself, but with the short notice and not being able to find funding to get there, I am unable to. So I am entrusting this letter to be read by my good political friend and comrade, Congressman Byron Dorgan, for I know he will lead me in the battle of what I am fighting for.

Even though I stand behind much legislation involving the handicapped, my concern at this time, as stated previously, is for provision of federal and/or state funding to prevent a specific group of handicapped people from having to be put into any type of institutionalized setting. By a specific group, I mean people who are in need of continual supervision because they cannot totally take care of themselves, but they are in good enough health to function in the homes and communities.

I am in the position that, with my tracheostomy, I need to be watched over constantly. Being paralyzed from the neck down, I need to be periodically suctioned and given air with an ambue. On a bad day, I may have to be suctioned and given air every 10 to 15 minutes. I am also on a portable respirator, but only during sleeping hours, for I have a form of sleep apnea, complicated by my having muscular dystrophy. But on a typical day, when the suctioning isn't really bad (maybe every 45 minutes to an hour), I can do almost anything and go anywhere, as long as I have an attendant with me. This is my most prized possession - my freedom. I can go about town; go on a trip; take a cruise abroid; even go to the moon; - just as long as someone's there beside me. What I also have on my side is youth and a perfectly sound mind, and these are qualities that thrive on the outside world and, by the same token, these are qualities that would wither and be damaged in the confines of an institution.

On February 25th, I received a letter from Mr. Dorgan informing me of your committee. Mr. Dorgan was honest in his feelings about the prospect of these hearings, saying that he felt pessimistic about the chances of expanding health care coverage. His reasoning for this was national outcry from the public over the rise in taxes when the catastrophic health bill was passed. I think we must ask ourselves as a nation, "What is more important, ' life and the quality of someone's life, or the almighty dollar bill?"

I would like the gentlemen of this committee to, for a moment, put themselves in my exact position and visualize an actual experience I'm about to retell. Picture yourselves, gentlemen, sitting at the dining room table on November 22nd, 1988, watching the evening news. A news story comes on showing the unveiling of the Stealth B-2 bomber. In a matter of minutes, you learn the cost of this sophisticated aircraft is $500 million per plane, and that there are going to be 132 of these planes built at a total cost of $70 billion. At this cost, it's my estimation that one-fourth of one wing of one of these planes could keep someone alive and healthy for the rest of his or her life, even if that person lived to be over 100 years! These planes were built for reasons of defense, to minimize the probability of an attack by our enemies -- in other words, to save lives. But where is my personal healthcare defense? I have no deterrent against an attack of death, because my prevention against such an attack is money, but all the needed money is being tied up in these planes. Is it necessary for the weak to die so that the fit have a better chance to live?

Continuing the scenario, another recent news article informs you that Japan spent 74 million dollars on the funeral of Emperor Hirohito. I'm not suggesting I or anyone else is more important than Japan's recently deceased ruler, but if a country can spend that large amount of money on the burial

of its leader, then why can't this country provide money for its living? All I'm really asking for is allocation.

For a final example in the scenario, I heard on the news a few years ago, a report on wasteful government spending. The case in point mentioned was a government study on why people fell off of their bicycles. I remember that the government spent "x" amount of dollars and time on this study. I don't remember the exact amount, but I do remember that it was quite high. Anyway, the conclusion of their study was that the reason people fell off their bikes was that they lost their balance. Anyone, without any background knowledge of the subject, could have come up with the same conclusion for only a pocketful of change. I'm sorry, but I give my life priority over why people fall off their bicycles. And it is my hope that the government will be more discerning in its endeavors.

The type of legislation I would like to see passed is this: If there was someone who was unable to take care of his or herself and needs an attendant of some sort around them at all times (which is not always feasible in an institution), and the person is functionally mobile and possesses the desire for home health care, then I feel that person should be provided health care coverage that would keep that person in his or her home as opposed to being put into any type of institutionalized setting. A person's doctor could also have a say in what type of coverage a certain person requires. For instance, if a doctor felt a person needed LPNs, then the federal and/or state government would fund only LPNs and no RNs or aides, and if a doctor felt it was only necessary to have aides, then funding would only be provided for aides, and not LPNs or RNs. Or, in my specific case, a combination. My doctor feels that I should have at least one licensed nurse on my staff at all times, but that the rest can all be lay persons, as long as they have an up-to-date CPR license. There could be a base rate as to how much an aide (or lay person), LPN or RN could start at, such as $5 and up for aides, $7.50 and up for LPNs, and $8.50 and up for RNs, with allowances for a certain percent raise as time goes by. I feel an established base rate is necessary to avoid high turnover and ensure proper quality of healthcare. If I were on such a government program right now, I would be lucky and only need one licensed nurse, thus being less expensive to take care of.

I also feel if such a program were to be set up, that the AMA shouldn't be allowed to take part as a go-between, simply because that would only cost the government more money. In other words, I feel a person should be able to hire whoever he or she wants, whether it be a licensed nurse or lay person. Hiring my own personnel in the last few years, I've found that, at first, I could hire a nurse for $7.50 an hour (now being $8.00) and as of recently, a lay person for $5.00 an hour. Where I live, in Fargo, North Dakota, there are organizations that provide nurses to people in their homes.

But where I can hire an LPN for $7.50-$8.00 an hour privately, these organizations will charge over $13 for the same service. So you can see why it's important to keep the AMA out of the picture.

Another reason I feel the AMA shouldn't be involved is for the fact that I've learned it's extremely important in home healthcare to have the freedom to hire whoever you want, when a person is around you for so many hours in a day. It's imperative that you hire someone you're going to get along with. Hiring someone you like, you eventually become friends too, which I've learned is very important. If one had to go through one of these organizations, the freedom of hiring would be taken away. More than likely, they would just send someone out to work for you, or at best, you would get to choose among a small staff, which is still no guarantee that you'll find someone suitable to your liking.

The future situation I'm facing is this: My father, who retired last October, will only receive this insurance policy through the school until he's 65, which will be next year. My future then will be up in the air, which causes me great anxiety, as I have feelings of no control of my future. There is no way my parents can take care of me on their own at their age. I need suctioning, sometimes quite often, and at times I need air. I need an attendant beside me at all times. In my home setting, I can be sure that I will get proper attending.

I also have a psychological problem. If I'm left alone for more than five minutes, my mind says to me, "Hey, Gyle, what if you stop breathing when there's no one around? Who's going to help you?" I then panic to the point where I half convince myself that I might stop breathing, and I actually do get short of breath (this stems from an experience I had as a teenager when I did, in fact, stop breathing). The only way I could be unattended with this problem is to be continually hooked up to a respirator, which is a service the local private institutions do not provide. Now, tell me, gentlemen, would that really be fair? If I were to be placed within four walls and had to be forced to live the rest of my life on a respirator, when I don't even have to be on one all the time, I know that all the pride and dignity I now have will be completely stripped away.

I guess another thing that bothers me about the situation I'm in is this: I see so many people ripping off the system and taking the government for everything they can get. I see people who are perfectly capable of working, but who either don't or won't. These people are pulling in all sorts of checks, such as workman's compensation, disability, unemployment, etc. Some get more than one check. They make their house payment, car payment, go out and have fun, all from free government money, when they have the ability to provide these funds for themselves. I, myself, am severely handicapped, needing

money desperately, and I have never taken advantage of the government. My bills can barely be met with the small government check I get. And what's more, being as severely handicapped as I am, I have had jobs in the past. I've sold jewelry, written for the college newspaper and three local magazines. I also applied for a receptionist position at Merrill Lynch, where I thought I could work out of my own home. I was actually promised the job, but then it was found out that I couldn't legally work for a brokerage firm from my home. My point is, with my severe disability, I don't have to work, and no one expects me to, yet I've always tried and always will, which is more than I can say for some people who are capable of working.

To further this point, vocational rehabilitation of North Dakota has agreed to fund a computer for me, - one especially built for the handicapped. The reason they agreed to fund it is that a year ago, I started writing a book on the machine I have now. I quit writing the book because my machine only prints. The new computer would allow me to do all the things a write can do. Vocational Rehabilitation has a lot of faith in me because I took the first few pages of my book and let an English professor of ten years from NDSU read it. He said that it had good potential for national publication. Since that time that Voc Rehab agreed to the computer funding, however, I found out that my father's insurance will run out in a year and a half. I almost feel quilty in accepting this computer, simply because I can't give the book my full concentration because of the uncertainty of my future -- and that certainly wouldn't be fair to Voc Rehab, not after they have just put their trust and faith in me. So, as you can see, it is very frustrating to not be in control of your own future.

President Bush, during his campaign, promised us a "kinder, more gentle nation." I hope these were not just idle, meaningless words. I hope, instead, that they were words of truth and action, and do apply to those in need, as it should be noted that I did not choose to be in the present medical condition that I am in. And I certainly did not choose to be born handicapped.

In conclusion, gentlemen, knowing that I may only have a year and a half of freedom of choice left, I feel like I'm in prison, sitting on death row, waiting for the governor to call and give me a stay of execution. The phone, gentlemen, sits before you -- Now you just have to decide whether you want to pick it up and use it.

Sincerely,

Gyle Peterson

Gyle Peterson

COMMENTS OF FHP, INC.

Background

FHP, Inc. is a federally qualified health maintenance organization with almost 30 years experience in running staff, group and IPA model health care delivery systems. The Corporation's total national enrollment numbers over 400,000 and includes almost 130,000 Medicare risk contract beneficiaries.

FHP, Inc. appreciates the opportunity to submit comments for the record on HMO Physician incentive arrangements and thanks the Chairman and the members of the Subcommittee for their consideration of our views.

The Need for Statutory Revision

Absent further amendment, effective April 1, 1990 Medicare Risk contractors will be prohibited by provisions of Section 1128(A) of the Social Security Act from entering into incentive arrangements with physicians or hospitals.

The current statutory language was enacted in reaction to problems created by certain hospital incentive plans which gave physicians cash when a medicare beneficiary's inpatient hospital charges were below the DRG payment level. While FHP concurs with the committee that payments which reward physicians for limiting care are inappropriate; we feel that the prohibition's broader application to pre-paid incentive arrangements is not appropriate or necessary.

FHP, Inc. respectfully submits that further study and review by the General Accounting Office (GAO) and the Physician Payment Review Commission (PPPC) has failed to identify and document specific problems which have resulted from existing managed care incentives arrangements. Therefore, FHP recommends that the statutory language be amended to permit the continuation of properly structured incentive arrangements.

Incentive Arrangements

It is FHP's view that all compensation systems whether prepaid group practice or fee-for-service create incentives. These incentives have to be structured and arranged in a way which gives the most appropriate and timely feedback to participating physicians.

FHP's quality assurance program supports each IPA/Group with an extensive system of quality assurance committees, review protocols, medical reviewers and member services representatives. Joint review committees include hospital, physician and FHP representatives and meet regularily to focus on quality and operational performance. In addition, FHP supports this system with FHP staff satellite offices which act as quality assurance service centers and house Medical Directors, quality assurance and utilization review personnel assigned to a specific IPA/Group plan.

The IPA and Group model plans which FHP operates in California, Arizona and New Mexico are based on a fairly simple reimbursement system. A typical model will have all the physicians, primary and specialists, bill against a common pool. The participating physicians are paid each month based on the total billings against the pool by all the physicians. Each IPA, on average has approximately 100 participating physicians.

There are subtle variations in this system because FHP negotiates separate contracts with each IPA, Group and Hospital.

Viewed broadly, FHP's incentive system is structured to achieve a balance that assures that each beneficiary receives

quality health care. Our system attempts to foster a partnership combining a sophisticated management system with a high standard of care which results in positive rewards for medically appropriate care.

FHP's Recommendations

FHP respectfully recommends that the statutory language be revised in the following manner:

- Protection should be given to appropriately structured compensation arrangements. Plans which integrate into their respective incentive programs strong quality assurance systems with enrollee satisfaction review and grievance procedures should not be prohibited.

- Amendments should specify that arrangements that reward physicians for withholding or reducing medically necessary services to a specific beneficiary are prohibited.

In closing, FHP would like to make two comments on issues that were raised in testimony given before the Subcommittee on April 25, 1989.

One witness suggested regulatory review of all contracts to assure that incentive arrangements are appropriate. As the third largest risk contractor and one which separately negotiates IPA, group, and hospital contracts each year, FHP foresees chaos and would submit that OPHC does not have the financial or staff resources to administer such reviews. At present OPHC regularly schedules in-depth compliance reviews which evaluate all aspects of each risk contractor. These on-going compliance efforts combined with the specific prohibition recommended above should be sufficient to guarantee that incentive arrangements are properly structured.

Another witness suggested in lieu of monthly incentive payments a type of annual reward would be more appropriate. Removing, in effect, the reward as far as possible from the health care event. If prohibitions are extended to cover incentive payment schedules, the law will eliminate an important tool for the timely evaluation of both under-and over-utilization of services. Problems can be identified early and solutions put in place which protect the beneficiary. It is ironic that putting TEFRA contractors completely at risk each month is acceptable, but that putting physicians partially at risk each month is felt to be inappropriate. The GAO has not provided any evidence that the timing of reimbursements is correlated with quality.

FHP, Inc. appreciates the opportunity to submit these comments. If the Chairman or the members of the Subcommittee have any questions please contact Janet Newport. Her number is (202) 223-5718.

HOMECARE™

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H.R. 1325
Standards for Private Long-Term Care Insurance:
One Step in Addressing the Long-Term Care Needs of America

Statement by

The National Association for Home Care

for the

COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON HEALTH
of the
U.S. HOUSE OF REPRESENTATIVES

Thursday, May 18, 1989
Washington, D.C.

Mr. Chairman and Members of the Committee, thank you for this opportunity to submit a statement for the record on H.R. 1325, The Consumer Protection for Long-Term Care Insurance Act of 1989, establishing Federal standards for private long-term care insurance. The National Association for Home Care (NAHC), representing approximately 6000 home health agencies, homemaker-home health aide organizations and hospices, has long supported strengthening standards and providing incentives for the private long-term care insurance industry and we wish to commend the Chairman and the Committee for their efforts. NAHC is pleased to support H.R. 1325 as one important step in meeting the long-term care needs of Americans.

The Role and Potential of Private Long-Term Care Insurance

The promotion of private long-term care insurance is part of NAHC's 1989 Legislative Blueprint for Action distributed to Congress early this year. As the Committee is well aware, very few individuals can afford to pay for an extended nursing home stay or long-term home health services out of their own pocket, yet neither Medicare nor current private insurance cover these services. According to the Health Insurance Association of America, there are some 1.1 million long-term care policy holders in America today. Even if all these policyholders were age 65 or older, they would still represent less than 5% of the elderly population. At the same time, a September 21, 1987 Report to Congress and the Secretary of Health and Human Services by the Task Force on Long-Term Care Policies states that "at age 65, people are estimated to have more than a 43% risk of entering a nursing home some time during the rest of their lives." However, financing long-term care is not just a problem for older Americans. By the year 2000, fully 40% of functionally dependent individuals will be under the age of 65. Private long-term care insurance has the potential to play a more significant role in meeting the financial burdens of long-term care.

NAHC has recommended a number of actions to address the deficiencies in the current insurance market. These include: 1) favorable tax incentives to promote the purchase of long-term care insurance policies by those who can afford it; 2) tax incentives to foster development of long-term care insurance through employer-based plans and vested retirement funds; and 3) removal of present restrictions on buying long-term care insurance through cafeteria plans and flexible spending accounts. However, even if these recommendations were implemented today, their effectiveness would still be greatly limited without the establishment of federal minimum standards for private long-term care insurance policies. Such standards have already had a major impact on similar problematic Medigap policies. As the provisions of H.R. 1325 are structured along the lines developed to regulate Medigap policies, commonly referred to as Baucus standards, we are confident that this legislation will have a similar impact on problems within the private long-term care insurance industry.

Private insurance will never be a total solution to the long-term care financing problem, but it can protect a significant number of people against potentially ruinous long-term care costs. This assumes that policy holders will have the opportunity to receive benefits under the policies. Unfortunately, many current policies are so restrictive and limited that often beneficiaries clearly in need of services will never receive benefits. Typically, the restrictions take the form of prior institutionalization, limits on the number of home visits that are covered, payment rates that are low to begin with or that are not indexed for inflation, and tight limitations on who may enroll. The greatest strength of H.R. 1325 is the elimination of prior hospitalization or other institutionalization as a condition for benefits (or to limit benefits based on receipt of previous higher levels of services). We applaud the strengthening of these provisions from the original National Association of Insurance Commissioners (NAIC) Model standards act to protect access to home care. Prior hospitalization or institutionalization requirements may be the single greatest deterent to receiving benefits, particularly home and community based services which are more cost effective and preferred by beneficiaries.

Home Health and Community Based Benefits

Home and community based services are ultimately in the best interest of both insurers and policyholders in that they often delay or eliminate the need for more costly institutional care by preventing a further deterioration in health which might necessitate admission to a nursing facility or hospital. Early outpatient intervention, community-based services, and home health care can often rehabilitate a patient to the point that they no longer need even these services on a long-term basis, let alone long-term institutionalization. Without such an option, an individual who could have received limited extended care at home to meet their needs, is now in need of expensive long-term institutional care, hospitalization or, under the worst scenario, have died prematurely. Home and community-based care is much more than preventive medicine, however. Many patients will not be rehabilitated and many will eventually require institutionalization, but most long-term care patients can continue to function independently in the comfort of their own homes if given access to home care services to help them with activities of daily living (ADL) or assist them due to a related level of cognitive impairment (Alzheimer's disease or other dementias). Forced institutionalization simply because of incontinence and transferring problems is simply wrong, but unfortunately all too common. Home care represents the opportunity for a patient to

remain in the comfort of his or her own home and with his or her own family. It keeps families together while allowing for the continuing independence of the individual and their inclusion in the mainstream of life.

While NAHC strongly supports H.R. 1325, we would like to see stronger provisions mandating greater access to home and community-based care benefits. Currently, only 40% of private long-term care policies provide for adult day care. Most current plans include a home health care benefit, but with the elimination of the prior institutionalization requirements that restricted access to this benefit, insurance companies may be prone to reduce this coverage. Companies may fear a sudden demand for home and community-based service without the prior institutionalization provisions to keep eligibility down to what they consider to be a manageable level. Our fear is that they will develop new provisions that will continue decreased opportunity and access for home care services. Steps should be taken to ensure future inclusion of home health benefits in all long-term care policies. Furthermore, the home health benefit should provide for adequate payment for services with inflation protection provisions. Inflation protection is particularly important. For private long-term insurance to reach its full potential, policyholders will be purchasing coverage earlier in life and continuing protection into their sixth, seventh, or eighth decades. Coverage for services at a fixed rate over a period of 20 or more years with even modest inflation would provide payments that are virtually worthless. All policies should provide at least minimal inflation protection. We hope the Committee will consider amending H.R. 1325 to provide for this protection standard.

Conclusion

Many insurance companies have already taken steps to improve long-term care policies by removing restrictions and limitations and expanding coverage and eligibility, but a clear standard for policies is still needed to maintain this trend. The private long-term care insurance industry has already seen a tremendous growth in the number of insurance companies offering policies. Today, more than 105 companies offer long-term care insurance. The standards established by this legislation will help ensure that these policies eliminate any remaining restrictive provisions and will help ensure that future insurance companies entering the field provide real protection with a variety of services available for policyholders.

Enacting standards for private long-term care insurance is but one step to establishing private insurance as an alternative for meeting the financial burdens of long-term care. Other measures as mentioned above are needed to fully develop the potential of the private insurance market, however. We hope the Chairman and the Committee will also take up legislation to address these concerns.

STATEMENT OF MARTHA McSTEEN, PRESIDENT
THE NATIONAL COMMITTEE TO PRESERVE
SOCIAL SECURITY AND MEDICARE

My name is Martha McSteen. As President of the National Committee to Preserve Social Security and Medicare, I speak on behalf of the organization's five million members and supporters. Most seniors fear becoming frail and dependent and purchase expensive private insurance policies to protect themselves against financial devastation. Until recently, seniors believed themselves protected by Medigap insurance only to discover that their policies did not cover long-term care. Many seniors now are beginning to understand that in order to have *any* chance of long-term care coverage, they must purchase policies that explicitly cover long-term care. Even so, most of these new insurance products to provide far less than adequate protection against chronic illness because of special requirements, limited coverage or other gaps.

Mr. Chairman, we applaud your efforts to bring the same type of standards to long-term care policies as the Baucus Amendment brought to Medigap policies. We support H.R. 1325 as an urgent and necessary first step to encourage states to require minimum standards for long-term care insurance policies until such time as mandatory Federal requirements can be imposed on Medigap and long-term care policies.

The Baucus Amendment encouraging states to adopt standards for Medigap policies has proven workable, if not perfect. When it became law in 1980, only nine states had standards. Only four years later, 46 states had adopted the model regulations.

H.R. 1325 creates an impetus for states to voluntarily adopt the National Association of Insurance Commissioners' (NAIC) Long-Term Care Model Act. Until recently the NAIC Model Act was seriously flawed, but at NAIC's December meeting the Model Act was amended to disallow a requirement for a three-day minimum hospital stay before eligibility for benefits. This was clearly an important change because an acute illness prerequisite would drastically reduce the number of people receiving benefits under such a policy. A majority of seniors requiring unskilled long-term care enter nursing homes directly from the community rather than from a hospital. We applaud the fact that H.R. 1325 goes a step beyond the NAIC requirement which still allows certain exceptions to insurance reimbursement for noninstitutional care. H.R. 1325 standards would prohibit a requirement of prior institutionalization before eligibility for home care benefits in all circumstances.

If states adopt the H.R. 1325 and/or the NAIC Model, seniors will be protected from many of the more obvious insurance abuses. They will not be dropped from a policy due to advanced age or disability; they will not have to wait longer than six months for eligibility due to preexisting conditions; and seniors will be protected from receiving services in unlicensed facilities.

The standards, if adopted, would require insurance policies to use a standard format and simple terms to describe benefits. Without a clear understanding of what is and is not covered, it is impossible for the consumer to compare policies. In addition, H.R. 1325 requires the Secretary of the Department of Health and Human Services to inform Medicare beneficiaries about current laws that prohibit certain marketing and sales abuses and to provide seniors with addresses and phone numbers of relevant state and Federal agencies. Finally, the Secretary would be required to set up a toll free number for the purpose of reporting suspected violations.

These and other provisions are helpful, but many shortcomings remain with long-term care and Medigap policies. While the Baucus

Amendment helped encourage states to adopt standards at least as stringent as the Federal standards, it did not eliminate abuses and questionable sales tactics by some insurance agents. Some seniors still have as many as eight or nine policies with overlapping coverage; some seniors still are being convinced to switch from one policy to another of equal value by a persuasive sales agent who may pocket a large commission. Such practices could be reduced by requiring clear disclosure statements about a sales agent's larger percentage of earnings from selling a new policy versus a renewal of an existing policy. Consumers should also be informed about the additional waiting periods for preexisting conditions when switching policies and the uselessness of duplicate of coverage. This information is important to seniors trying to decide whether to renew or switch policies.

Some states do a yeoman's job of overseeing insurance products in their jurisdictions; other states do not. Federal oversight and Federal sanctions are sorely missing in the insurance arena. In a recent Energy and Commerce subcommittee hearing, it was pointed out that numerous Medigap insurance products are not living up to the expected 60 percent loss ratio. While there have to be exceptions to this rule for new products, many abuses were cited. The Federal government has been afraid to regulate the insurance industry for too long -- in spite of clear violations of minimum ethical sales and advertising techniques by some insurance companies.

The National Committee believes that a public-private solution to long-term care is necessary. Neither entity can adequately provide the protection seniors require. At this time, when Medicare covers less than two percent of long-term care, good private insurance products are surely needed on the market. But even after we see Medicare expanded to cover long-term care, there will be inevitable gaps for private insurance to fill. That is why it is important that we establish, at least, minimum standards for these insurance products as soon as possible. Because we recognize that private insurance will remain an important factor in the long-term care public policy, we also support legislation to encourage employer and employee purchases of good long-term care insurance policies through conversion of life insurance and/or certain changes in the tax code.

While the long-term care insurance business is rapidly growing, still only an estimated half million individuals have purchased such policies. From the research by several consumer groups, we know that many of the products on the market today are overpriced and will not adequately cover seniors in their long-term care needs. In the meantime, we support H.R. 1325 as a first important step in fostering minimum standards.